MEDICARE PAYMENTS AND QUALITY HEALTH CARE FOR RURAL OLDER AMERICANS

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOUSING AND CONSUMER INTERESTS

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

JUNE 9, 1986, CUMBERLAND, MD

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MEDICARE PAYMENTS AND QUALITY HEALTH CARE FOR RURAL OLDER AMERICANS

MONDAY JUNE 9, 1986

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON HOUSING AND CONSUMER INTERESTS,
Cumberland, MD.

The subcommittee met, pursuant to notice, at 10 a.m., in the auditorium, Allegany Community College, Willowbrook Road, Cumberland, MD, Hon. Don Bonker (chairman of the subcommittee) presiding.

Members present: Representatives Bonker and Byron.

Staff present: Michael F. Rodgers, staff director, Susan Able, research assistant, of the Subcommittee on Housing and Consumer Interests; Jackie Sullivan, legislative assistant, and Al Beachley, legislative assistant, of Representative Byron's staff.

STATEMENT OF CHAIRMAN DON BONKER

Mr. BONKER. The subcommittee will come to order.

The Select Committee on Aging, Subcommittee on Housing and Consumer Interests, is here in Allegany County today to conduct a hearing on the subject of health care for senior citizens.

I want to thank Mrs. Byron for the invitation to be here. She serves as an important member of the House Select Committee on Aging, and has been an invaluable member of this subcommittee.

I would like to compliment Mrs. Byron on a beautiful district. I used to think I had the loveliest congressional district in the country, because I come from the great Northwest and have in my district what is left of Mount St. Helen's. But I have to admit that driving up here this morning and coming through Frederick and Hagerstown and now into Allegany County, that you, indeed, represent a beautiful area, and I can also tell, a very active and vibrant people.

Your Congresswoman and I are very busy these days dealing with a variety of national issues as we attempt to confront our deficit problems in trade and taxes, and I know that Mrs. Byron feels like I do in trying to address some of these very difficult issues.

I feel a little like the reluctant son who didn't want to get out of bed and go to school until his mother came into the room. They got into something of an argument, and finally in exasperation, he said, "Mother, give me one good reason why I should get out of bed and go to school this morning." And she said, "I'll do better than that. I'll give you two good reasons. No. 1, you're 45 years of age,

and No. 2, you're the principal." So we are the principals and we have got to get out of bed and face some of these very difficult issues.

Your Congresswoman and I both represent basically rural areas that pose unique problems for senior citizens. Access to services transportation, and access to adequate nutritional programs are really more difficult in rural areas than they are in urban communities.

The rural elderly should have the same opportunity and the same level of services so that they can live with the same dignity that other senior citizens in this country enjoy.

Today's hearing will attempt to identify problems that are unique to the rural elderly under the Medicare Program, and will provide a balanced perspective the impact the Medicare prospective payments system has had in rural areas.

This year, as many of you know, we celebrate the 20th anniversary of the Medicare Program, which was inaugurated in 1965. I was a member of the Senate Select Committee on Aging staff in 1965 when this program was enacted and I recall at the time there was considerable enthusiasm that Congress had put into place a program that would fully protect senior citizens, and at least cushion them against the skyrocketing health costs and insure their medical well-being in future years.

At the time that the Medicare Program was enacted, the concept provided for full coverage, 100-percent coverage, and despite the enthusiasm and the vision of that program of providing 100 percent, the compromises at the time made possible a program that provided only 80 percent. Even that was better than nothing.

But today we have learned that Medicare covers only 45 percent of related health care costs. So in that sense, it has fallen vastly short of its early expectations. By 1981, health spending, not paid by Medicare, equaled almost 20 percent of the average per capita income of persons over 65.

This, ironically, is the same share of income consumed by health care spending before the enactment of Medicare. So, it seems like we have come back to where we started in terms of how much out-of-pocket expense is going to cover health care.

Congress needs to look closely at this program. On the one hand, we want to ensure the solvency of the trust fund and the viability of the payment program. On the other hand, we want to make sure that senior citizens get the full coverage to which they are entitled, and which was originally committed when Medicare was enacted 20 years ago.

But we are not going to know the full impact of this program until we come into different areas of the country, particularly those of rural makeup so that we can hear firsthand from those who are involved in the program, and most importantly, from the senior citizens who are the beneficiaries.

That is why I am so pleased that Congresswoman Byron has taken the leadership to bring this committee into Allegany County, so that we can hear firsthand from the constituents who are involved here. It is really a privilege to have the committee here. I think the testimony that will be presented today will serve as a valuable source of information as the House Select Committee on

Aging continues its work on influencing policy decisions concerning Medicare and health care for senior citizens.

At this time, I would like to call upon your very distinguished Congresswoman, Mrs. Byron, for opening comments that she might have.

STATEMENT OF REPRESENTATIVE BEVERLY B. BYRON

Mrs. BYRON. Let me first of all take this time to give my special thanks to the chairman for really granting the request that I had made to him as a colleague, as a friend, but more important to one who is very concerned about our senior citizens in really looking at the problems of our rural elderly under the Medicare Program.

Over the last few years we have all received numerous complaints in our congressional offices, from citizens and many of the doctors and physicians in our area about the quality of health care for our senior citizens. I have also heard concern about the diminishing quality of health care for senior citizens and Medicare patients being prematurely discharged from hospitals.

I remember consistently on district tour, groups of senior citizens would come in to me, and in some cases, physicians would come in to me, concerned about what is really going to happen to our seniors. Many of these constituents believe there is a real need to expand on the home health care benefits and other supportive services that we are seeing under Medicare.

The purpose of this hearing is to gather more information from Medicare beneficiaries, from those individuals responsible for providing the services, from organizations on aging, and the agencies that administer Medicare to determine if the health care needs of our elderly really are being met.

In 1983 Congress approved a new payment system for Medicare reimbursements to hospitals, known as the prospective payment system. This new system was designed to control costs which were seen escalating, by paying the hospitals a predetermined price for their services. These fixed sums really are based on standardization of diagnostic related groups.

You know, when you are developing legislation, you have to develop it for the entire country. It is very difficult in many of those cases to address the needs of our rural areas, at the same time addressing the needs in our urban areas. I think that Congress has a very difficult task in addressing those across-the-board needs and making sure that the rural area medical needs are met.

In the past, hospitals were routinely reimbursed for all costs in rendering services to the Medicare patients. Today those payments to hospitals are based on the hospital's historical costs. These payments are sufficient to cover the full cost of caring for patients in an efficiently run operation, but in many of our rural areas, it is very difficult to have the volume that you see in a metropolitan area, and the Federal Government doesn't really dictate how the patients are to be cared for in hospitals. But this remains, as it has always been, the responsibility of the hospital and those attending physicians.

In our small rural areas, we have many more difficulties than you do in a very large metropolitan area. And I think the amounts

are based on the average cost of treating a patient with a particular medical condition. If the patient can be discharged sooner than the average, then the hospital is permitted to keep the balance. On the other hand, if the patient requires a hospital stay in excess of the average, then the hospital must absorb those losses.

Once again, many of our rural hospitals operate on a very, very small margin, on a very difficult case of making ends meet. And this approach is intended to encourage hospitals to provide only the essential medical services to the Medicare patients.

Although recent reports show that the new system has resulted in substantial savings on the Medicare program, I have been contacted by many of our senior citizens and their families, who are concerned about our elderly being discharged from hospitals before they are medically fit. I am sure Congressman Bonker can agree with me in his area, that he is seeing the exact same thing happen.

It is particularly distressing, and I will cite one example in Garrett County, where the elderly must contend with severe winters; distant hospitals, and very limited out-of-hospital care services. Therefore, to be discharged early in those cases, when sometimes it is a questionable discharge, we must make sure that those discharges are taken care of and those individuals are covered.

I think we would agree that every reasonable effort should be made to insure the financial stability of the Medicare system. However, the cost saving measure should not jeopardize the quality of the health care of our elderly. Senior citizens deserve quality health care without that added worry.

I will continue my own personal commitment to providing basic health care benefits to older Americans and improving the current reimbursement system.

We have a very distinguished panel of witnesses here today. I am sure they will give us very many valuable insights into the effectiveness of Medicare in meeting the special health care needs of our rural elderly.

I am very proud to say that in my two western counties, Allegany and Garrett, almost one-fourth of that population are senior citizens. I think that really drives home to me the need for the health care.

We have comment sheets that are going to be handed out for anybody that wishes to add some comments which we will make a part of this record. We have several very distinguished panels today. I think we had enough panels and people requesting time to testify that we could have been here for the entire week on the testimony, and I think that is good, because it shows the concern. It shows the viable interest of our senior citizens.

I was delighted when I walked in today and noticed the number of signs that were here. First of all, when I walked into the back of the room, having not seen what was on the sign, I wasn't sure whether we were going to be in for a hostile group or not, but I think the signs very much convey your message. They add a great deal, I think, to a hearing, and I can assure you they are not lost on the two of us up here. So, I am delighted for those people that have taken the time to come out today, not only to testify, but for those of you who are not testifying, but that are concerned, that

are interested and want to know what they can do to help us make the decisions that we have to make.

So I think on that note we will go ahead with our first panel, and I will turn it back over to the Chairman.

Mr. BONKER. Thank you, Beverly, and let me also note that the turnout here is very impressive. We have had hearings in other places in the country. I think this is the largest and perhaps the most enthusiastic turnout and I certainly will take back to Washington, DC your message that seniors care about Medicare.

We shall now have the first witness, and I would like to call upon your Congresswoman to introduce the State Senator, who will be our lead off witness.

Mrs. BYRON. I would first of all like to thank Senator Bambacus for being our first witness today. At the same time I want to also note that we have—which I think is a great credit to these communities—we have another State Senator, Senator Cushwall, and Delegate Callas in the audience. We have numerous county commissioners. We have members of the city council and elected officials who are concerned about where our seniors are and what type of care we have.

So, John, if you will please proceed.

STATEMENT OF STATE SENATOR JOHN N. BAMBACUS, MARYLAND LEGISLATURE

Mr. BAMBACUS. Thank you, Chairman Bonker and Congresswoman Byron. We are especially glad to have you here in Allegany County. I think, as you just mentioned, the fact that we have this tremendous attendance here today is a manifestation of the interest that people have in what you are doing, and again, many, thanks to all of you. We, of course, have come to expect this from Congresswoman Byron. She has been very active on these matters. She has been very helpful to my office and we are very appreciative of that.

Mr. Chairman, Congresswoman Byron, the seminal issue, it seems to me, before us today is whether or not we as a society, to paraphrase an editorial in yesterday's Washington Post, are buying the right level quality of medical care and paying the right price for it.

As a member of a rural community hospital board in Frostburg for the last 11 years, I can tell you I am well aware of the problems that are associated with providing adequate health care services to meet the needs of elderly individuals in rural areas, and especially in the Appalachian region of western Maryland.

In fact, a great deal of work has been done to improve health care for elderly persons statewide and to provide for the special needs of the rural elderly population. While the work of the U.S. Congress, House Select Committee on Aging is significant and substantial, so too are the challenges facing local and State officials who are responsible for providing leadership and policy to address the health care needs of elderly persons in rural areas.

The State can respond effectively to our elderly citizen's health care needs. Indeed, Mr. Chairman, and Congresswoman, under the new federalism, we must work harder than ever to do our job, and

the fact that all of us are here today shows the cooperation, the intergovernmental cooperation that must continue to exist between Washington and State capitals.

Our responsiveness, it seems to me, is evident in the in-home service programs available throughout the State and in our policy of providing community based support services. By recognizing and responding to the needs for community based support services, the State of Maryland has coordinated a series of complimentary programs designed to reach individuals who need assistance with daily needs to continue their independent living arrangements in the community rather than in institutions. And I think this is an area which the State of Maryland is in the forefront.

Let me remind you that while an estimated 10 percent of the population of Maryland is over the age of 60, in most rural counties, and Baltimore City, the percentage of elderly individuals climbs as high as 16 percent. As Congresswoman Byron has already mentioned, in Allegany and Garrett County, that number is close to 25 percent.

Considering the increased life expectancy and the migratory patterns of former urban dwellers these numbers are likely to increase in rural nonmetropolitan areas. As many of you already know, elderly persons in rural and urban areas have much in common. To a great extent the health care needs of the two populations do not really differ significantly. They share, for example, the need for more services for chronic care, the lack of cost-effective health care delivery systems, the need for more trained health professionals and para-professionals. However, it is commonly acknowledged that the rural and urban elderly must compete for services and I think I would like to underscore that, that we find ourselves competing for services between the rural areas and the metropolitan areas.

Researchers at the State level have determined as early as 1978 that the resources devoted to elderly health care were unevenly distributed, and I would ask your staff make note of this, because I really think this is the heart of the problem. In Maryland, we are guilty of the same thing, and I think this is an important matter.

The approach in Maryland has promised more viable solutions to many stubborn problems. The problems have not entirely abated, but substantial progress can be documented.

Maryland's Gateway II Program is administered by our State's Office on Aging. However, I might add that it just became available to the rural areas this year. It was a pilot program that began in the metropolitan areas, and it was only after constant pressure from the rural areas that we are able to finally have that extended to the rural areas of the eastern shore, southern Maryland and western Maryland.

This program provides funds for direct services and case management through local interagency committees. The program is designed to service the health related needs of elderly individuals who cannot be accommodated in the community setting through existing traditional service programs. Where the social service agencies and health institutions leave off, Gateway II fills the gap. The funds, which most of us refer to as gap-filling funds, provide for such things as chore and heavy chore services, personal care,

medication, cash to families who have a special need, and adult day care.

Formerly a pilot demonstration program, the General Assembly recently passed legislation this year to extend the program to the entire State. In this country alone, it is my understanding that $118,000 budget is proposed for fiscal year 1987 gap-filling funds.

In closing, let me ask you to bear in mind, please, the following information on the rural elderly population in Maryland's nonmetropolitan rural areas, based on recent Census figures.

In our rural communities, 26 percent of the elderly persons are over the age of 75; 57 percent of the aged citizens are married; 28 percent are widowed; over 52 percent are female; 15 percent are nonwhite minorities; 74 percent are not in the work force; 83 percent, I am pleased to add, are home owners; 34 percent live below the poverty level, and that is a big problem that others will be talking about this morning and early this afternoon. Seventeen percent, believe it or not, do not even have flush toilets in Maryland, so we have got some rather basic problems in these areas; 14 percent are without telephones and 21 percent do not have automobiles or access to automobiles.

These facts and those that will follow this afternoon give us a profile of people with critical needs. With your help we can provide the leadership to structure programs to serve those needs.

Thank you very much, Mr. Chairman.

[Supplemental material submitted by Mr. Bambacus follows:]

MARYLAND

Demographic, Socioeconomic and Need-related Characteristics of Persons Age 60 and Over in 1970 by Type of Geographical Location

Characteristics	Metropolitan Urban	Metropolitan Rural	Nonmetro. Urban	Nonmetro. Rural	Significance Levels of t-tes UM-UN	UM-RM	UN-RN	UM-RM	UN-RM	UM-RN
Demographic:										
Mean Age	69.2		70.0		-					
% 75 and Over	23.9		26.3		-					
% Married	53.1		57.9		-					
% Widowed	32.3		28.2		-					
% Female	53.6		52.5		-					
% Nonwhite	9.2		15.8		.01					
% Migrants	10.0		8.8		-					
Socioeconomic:										
Mean Yrs. Schooling	8.6		8.2		-					
% Not in Labor Force	69.8		74.2		-					
Mean Job Income	2278		1023		.001					
Mean Bus. Income	85		200		-					
Mean Farm Income	84		129		-					
Mean Soc. Sec. Income	519		623		.05					
Mean Welfare Income	23		31		-					
Mean Other Income	931		693		-					
Mean Person Income	3962		2753		.001					
Mean Family Income	10249		5970		.001					
Need-related:										
% Homeowners	82.4		80.0		-					
Mean Persons per Unit	2.69		2.5		-					
% Living with Child	12.0		7.1		.01					
% Living with Sibling	2.6		4.5		-					
% Below Poverty Level	13.7		34.0		.001					
% W Rent = 35+% Income	13.1		42.4		.05					
% W/out Flush Toilet	10.0		17.3		.001					
% W/out Telephone	8.1		14.2		.01					
% W/out Automobile	15.2		21.8		.01					
N (100s)	457		596							

Source: Ecosometrics' Analysis of Public Use Sample, 1970.

Mr. BONKER. Senator, Thank you. You may want to remain for a question or two. Congresswoman Byron, do you have any questions of the Senator?

Mrs. BYRON. I do have one, and that is that you talked about the Gateway II Program. How long did that take to get to the rural areas as opposed to the metropolitan areas when it was originally a program?

Mr. BAMBACUS. Congresswoman, it seems to me it has been nearly 4 years.

Mrs. BYRON. There is another program which was just started in Baltimore and there was a very good article in the Sun on it the other day, and that is, it is really a preventive care program. Preventive medicine has always been very high on my profile because I think in the long run it is so much more cost-effective, and this is one that originally started in the Baltimore area in the large concentration of senior citizens' centers.

I just was curious. It is called Health Check, and I was curious as to what type of a timeframe we would be looking at if we were going to be able to get such a program through in our senior citizens' centers here. And basically it is a screening program for our seniors in their centers on a regular basis, maybe once every couple of months or so for those that are interested to avail themselves of checking on dental or hearing or glaucoma or eye programs.

Mr. BAMBACUS. Congresswoman, is this a publicly funded program as far as you are aware?

Mrs. BYRON. State.

Mr. BAMBACUS. State funded? We do not have that up here, but I tell you what we do have, which I think is another good sign. We find the private sector, through our four hospitals in Garrett and Allegany County, do a lot of this on their own, and I might add, at no cost or little cost to our citizens.

So it is like anything else, we will be spending a great deal of time on it. As you know, the rural areas have a tougher fight ahead of them, it seems. We are able, it just takes us a little while longer, but you can be assured that this is at the top of our agenda.

Mrs. BYRON. Well, it is a program that I think is quite good.

Mr. BONKER. Thank you. The Senator is one who is close to his constituency. Given the sizable elderly population you have in this area, noted by the statistics you shared, what do you find is the greatest problem facing elderly citizens in this area? Is it health? Is it housing? Is it transportation? What is the most common problem?

Mr. BAMBACUS. Of course, it is all of them, Mr. Chairman. But I would say as evidenced by the attendance here that the health situation, I think, is the worse, because it can be catastrophic. The others are problems, but we are able through social agencies, both private and public to meet, for example, most of the transportation needs, although you will hear problems with the handicapped and others that come up.

I really think the biggest potential problem is the catastrophic effect that health care costs can have. You will hear again from the consumers, and they certainly have more to say than I, and more important things to say than I. The fact that many of the

people that go into our hospitals, for example, are limited, because of the DRG program. That is, they may have a serious problem in which they can only stay for 2 or 3 days or as outpatient care or whatever you have, and they have serious problems.

The hospitals are caught in the middle of all of this and I am sure you will hear from some of the administrators today. Many of the hospitals, though, do have informal policies of trying to take care of the folks and work it out.

I really think we have got to take a close look at this DRG program, and give it much more flexibility than it currently has.

Mr. BONKER. Well, let me ask you about nursing homes and the program. I know in many rural areas, nursing home facilities do not accept Medicare patients. Maybe they don't feel that the reimbursement rate is sufficient, or they don't want to meet all the criteria, but if this program is to work well, the idea is that the patients would move from hospitals into nursing homes.

Do you have a problem in this area where there are insufficient Medicare beds to accommodate new patients as a result of DRG being imposed on hospitals?

Mr. BAMBACUS. Mr. Chairman, I don't have the statistics, although others will that follow me. But I think that, yes, it is a problem, and at the same time, yes, the nursing homes have been cooperating with the hospitals, but because of a lot of these cost care containment edicts that are coming not only from Washington, but from the states as well as we try to cut our costs, we are doing it, if you will, in an across-the-board fashion as opposed to taking a look at the personal needs of individual patients.

Mr. BONKER. Well, thank you very much, Senator, for being here and to your colleagues, for their attendance at today's hearing.

We will now invite to the witness table Marilyn Koch, who is the Acting Regional Administrator. This is region III of Health Care Financing Administration. This is the Federal agency that administers the health portion of social security, the Medicare program. It is often controversial, but always represented by highly qualified people.

Ms. Koch, it is a pleasure to have you here today. You may submit your written statement and summarize or you can read your statement, whatever you are comfortable with.

PANEL ONE: CONSISTING OF MARILYN KOCH, ACTING REGIONAL ADMINISTRATOR, PHILADELPHIA REGION, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF MARILYN KOCH

Ms. KOCH. Mr. Chairman, I would prefer to read the written statement.

I am delighted to be here today to discuss the quality of health care for the elderly living in rural areas. I want you to know that we share this committee's interest in assuring that Medicare is achieving its goal of providing in a cost-effective manner high quality services that are both medically necessary and appropriate.

High quality medical care has a longstanding tradition in this nation. The Medicare program has played an important role by as-

suring the continued accessibility to quality health care for elderly Americans including those in rural areas. Today, we face a challenge to maintain the tradition of quality in all settings where health care is delivered while providing incentives to moderate the rapid growth of health care costs which in the early 1980's were threatening the viability of Medicare and other private insurance programs. Through reforms and refinements, I believe we are seeing a change in behavior in the health care system, both in how services are delivered and in how they are paid. Everyone is involved; consumers, providers and third party payers. Consumers of health care services are becoming wiser shippers, spending their health care dollars where they receive the most benefits. Industry-wide cost increases have slowed and hospitals and insurers are reaping the benefits of careful utilization of resources.

We are also seeing fundamental changes in how health services are being delivered. Services previously provided in hospital inpatient settings are now being performed in the outpatient department. More physicians are opting to provide services under salaried arrangements through their involvement in health maintenance organizations and group practices rather than under the traditional fee-for-service mechanism. Physicians are becoming acutely aware of the costs of health care services and procedures they order for patients and are being asked to make judgments on the necessity of marginal services. Changes are being seen in hospitals as they develop more cost-effective methods for providing services, especially services involving high technology procedures. For example, patients with kidney stones can now be treated without costly and uncomfortable surgery through a procedure called lithotripsy. Although the financial investment in the equipment is significant, eventual savings accrue through decreased lengths of stay and surgical fees.

Nationally, much of the progress we have made in containing the growth of health care costs has been accomplished through the implementation of the prospective payment system. Two and one-half years into PPS, the evidence indicates that the system is successfully providing a positive incentive for hospitals to contain costs while maintaining quality of care. For example, our data show that both urban and rural hospitals have demonstrated a significant decline in the average stay; nationwide urban hospitals are experiencing an average stay of 8.2 days and rural hospitals 6.7 days. Although definitive data on the impact of PPS across the nation is still being developed for the first year's operation, early estimates indicate that hospitals in both urban and rural areas have experienced a general improvement in their financial position since the implementation of PPS.

Although I have briefly mentioned the Medicare prospective payment system, it is important to understand that hospitals in Maryland are paid under a State rate-setting system in which Medicare participates with all other payers.

As PPS was being developed, Maryland was already conducting a demonstration project which established payment rates prospectively for all payers through the Health Services Cost Review Commission. Under this system, hospital payment rates are set individually, geared to the needs and market pressures of each hospital.

Prior to 1976 when the commission was first established, Maryland's rate of increase in costs measured by payments per admission was more than 34 percent above the national rate. In 1980, Maryland had shown such progress in controlling costs that the requirement to return to the Medicare principles of reimbursement was waived as long as Maryland could continue to demonstrate a rate of increase below the national average. Last year, Maryland's rate of increase for the hospital's payment per admission was still one percent below the national average of 8.34 percent.

Hospital rate-setting systems consist of three major functions:

One, a budget review system is used to develop an initial set of rates per unit of service in the various revenue-producing departments. Under this system, all hospitals are required to submit budget data for each of seven cost centers for annual review.

Two, the inflation adjustment system was instituted to allow hospitals reasonable rate increases annually while avoiding the administrative burden of a full budget review. It considers inflation adjustments, volume adjustments, changes in payer and case-mix, and certain passthrough costs.

Three, the guaranteed inpatient revenue system, the system most analogous to the Federal PPS. This system builds on the inflation adjustment system by determining the average charge for each diagnosis for each type of payer then adjusting for market forces and service intensity. It also provides for year-end reconciliation. The Maryland system provides incentives just as the Federal system to control the utilization of health resources, and guarantees payment for each case treated by the hospital.

By basing payment on the actual cost experience of each hospital, the Maryland payment system affords a certain protection to rural hospitals which cannot increase operating efficiencies to the extent that urban hospitals can due to their smaller size and scope of service. In addition, 3 of the 14 rural hospitals have opted to participate in Maryland's capitation payment system. Basically, under this system, a hospital is guaranteed a total amount of revenue independent of the amount of services provided by the hospital.

I would like to take a moment here to speak briefly about other types of care; skilled nursing facilities and home health agencies and alternate delivery systems providing care under capitation arrangements, such as HMO's. Maryland's 114 SNF's and 95 home health agencies provide post-acute benefits which are important components of the Medicare program. By providing Medicare coverage of acute hospital, SNF, and home health care, Congress recognized that in the treatment of illness, a continuum varying levels of care were often appropriate in order to ensure continuity of care.

The purpose of the Medicare SNF and home health agency benefits has always been to avoid prolonged hospitalization and provide services to those beneficiaries whose care needs are below the acute hospital care level but whose conditions are such that they are under the care of a physician and in need of skilled nursing care. Patients are discharged from acute care hospitals to SNF's or home health agencies on a physician's orders and the care in these settings must be prescribed by a physician, thus ensuring the continuity of physician oversight.

We are seeing an increase in the number of SNF's and home health agencies in response to patient need. The percentage increase in SNF admissions for the period 1983–84 has been accompanied by the the increase in certified facilities, both have increased by about 5 percent. Home health care is one of the most rapidly growing benefits covered by Medicare both in terms of the number of beneficiaries served, the number of patient visits, and the increase in expenditures. For example, 1,190,000 beneficiaries received Medicare home health services in 1982 compared to 1,320,000 in 1984. Similarly, the number of home health visits per 1,000 Medicare enrollees increased from 1,060 in 1982 to 1,330 in 1984. HCFA expenditures for these services increased from more than $1 billion in 1982 to over $2 billion in 1985 and is projected to reach almost $4 billion in 1990.

The growth in the number of providers also demonstrates that increased demand for these services is being met by the industry. For example, the number of home health agencies has increased from 3,639 in 1982 to 6,012 so far this year. The number of Medicare-only certified SNF's increased from 276 to 495 and the number of dually certified, such as Medicare and Medicaid SNF's, rose from 5,233 to 6,243 during the same period.

Other alternative methods of providing care include HMO's, competitive medical plans, and other forms of capitation. These organizations provide a continuum of case-managed care, often including greater benefits than under the traditional Medicare program for about the same or slightly higher cost. In addition, HMO's have traditionally emphasized preventative care necessary to lower more costly forms of utilization. Medicare patients would, of course, benefit from this orientation as preventive services have not traditionally covered as a Medicare benefit. We believe that capitated programs offer great potential for providing high quality services to our beneficiaries in a cost-effective manner. Although currently most HMO's are located in urban areas, there are some types of capitation which we are exploring that would work well in suburban and rural areas. For example, independent practice associations or geographic capitation arrangements might be more suited to rural areas. In Maryland, there are three HMO's that include suburban and rural communities in their service areas, Care First of Baltimore, Health Plus located in Riverdale, and Maryland IPA, Inc., located in Rockville.

Let me speak more specifically about our efforts to assure quality through the peer review organizations, our survey and certification screens and the efforts of our Office of Beneficiary Services to help Medicare beneficiaries understand their coverage.

Through both PPS and Maryland's cost containment system hospitals are encouraged to provide only those services which are medically necessary, to manage their resources more efficiently, and to provide care in the most appropriate setting. The most crucial objective throughout the payment process has been to maintain quality and access to care for our beneficiaries. The Peer Review Organization—PRO—amendments of 1982 put a strong medical review mechanism in place. The PRO review functions were further strengthened in the PPS legislation to assure that fi-

nancial incentives would not adversely affect the quality of services provided to Medicare beneficiaries.

The PRO program is a dynamic medical review system that we are continuing to refine as we gain experience. We are now entering the second 2-year contract period with PRO's. In the second contract period, PRO's will be placing much greater emphasis on quality review, using generic quality screens to identify quality problems and focusing intensified review on any problems identified. PRO's will also review all readmissions to hospitals within 15 days to assure that patients are not being discharged prematurely. In addition, recently enacted provisions give peer review the authority to deny payment for poor quality care, thereby increasing the effectiveness of these organizations.

Since Maryland is a PPS waivered state it operates under a PRO contract which is unique. A principal difference is that review in Maryland encompasses both length of stay and intensity of services since these are a part of the State reimbursement system. Maryland's utilization objectives deal with reducing unnecessary ancillary services and invasive procedures as well as reducing the number of admissions that could be delivered on an outpatient basis. The Maryland PRO's quality objectives address postoperative complications and hospital readmissions for poor care, among others.

In all cases where a PRO finds poor quality, corrective action will be taken, ranging from education of the individual physician or hospital, to intensified review, and ultimately to exclusion from the Medicare Program where appropriate.

A major component of our quality assurance program is the survey and certification process which has been in place since Medicare was originally enacted. This activity protects the health and safety of individuals by assuring that every type of health facility participating in the Medicare and Medicaid programs meets rigorous standards.

Although the current survey system has had a high degree of success in assuring appropriate care in a safe environment it is primarily focused on the facility itself. We believe, however, that the focus rightly belongs on the patient and are about to implement a new survey tool, the patient care and services assessment which will enable us to provide an indepth review of care through actual observation of the care being provided. We also are requiring State survey agencies to begin home visits to determine the efficacy of care delivered to our beneficiaries in the home setting.

Additionally, fiscal intermediaries and carriers continue to be evaluated annually to assure that medical review determinations are accurate and are in conformance with HCFA guidelines and instructions. These checks protect our beneficiaries from inaccurate determinations by the intermediaries.

Another area that has concerned us is the continuing misunderstanding by some of the PPS, the PRO review responsibilities and the rights of patients to an appeal. It is the responsibility of the hospital to provide all necessary services regardless of the length of stay. In order to increase beneficiary understanding of this fact, we have instructed all hospitals to give beneficiaries information upon admission about their appeal rights in cases where the beneficiary

believes discharge is occurring too early. In late February, a letter entitled "An Important Message From Medicare" was provided to all intermediaries in the country for distribution to Medicare hospitals. Hospitals are required to give the statement to beneficiaries upon admission so that they know before services are provided what PPS is, how it operates, and how a patient can appeal. We have also sent instructions to PRO's concerning their monitoring of hospital compliance on the distribution of this information to beneficiaries. In addition, we are revising and consolidating the pamphlets which explain PPS and the appeals provisions under Medicare and are also developing a new pamphlet to better educate Medicare beneficiaries and their families regarding hospitals stays. The 1986 edition of Your Medicare Handbook has already been revised to include appeal rights, to assure that the information is fully current.

In addition, we have included in the new PRO contractual scope of work a community outreach program to help beneficiaries understand the role of the PRO and their appeal rights. We will also continue to work with groups interested in developing informational publications on the appeals process.

We believe that informed consumers and their families can do a great deal to protect their own rights and to influence the efficiency of the health care system. We will use every avenue available to us to assist our beneficiaries in becoming their own best advocate.

In conclusion, we are extremely pleased with the progress of both the Federal PPS and the Maryland Cost Commission payment system and the performance of peer review organizations in containing the growth of hospital expenditures while assuring that high quality care is maintained. We must compliment the hospitals, SNF's, and home health agencies in rural Maryland on their cooperation with Medicare's quality assurance programs in making certain that older Americans in rural areas have continued access to high quality care.

The responsibility to ensure quality of care does not rest solely with the Government. It is a responsibility which must be shared with physicians, providers and consumers. We look forward to continued cooperation in our shared goal of ensuring that every patient receives high quality, medically necessary care.

Mr. Chairman, thank you. I will answer any questions.

Mr. BONKER. Thank you, Mr. Koch.

Congresswoman Byron, do you have questions?

Mrs. BYRON. I have a couple, and I will try to be fairly brief, because we have a very large number of witnesses. On page 7 of your written statement you talked about rural HMO's and you cited rural areas of Rockville, Riverdale, and Baltimore. Were you to look outside in western Maryland, you would quickly discover that Rockville, Riverdale, and Baltimore are not exactly rural areas in that concept.

I think the thing that worries me is the services previously provided in many of the hospitals as inpatient settings are now being performed by outpatient departments. In the rural areas, by and large, many times individuals have to travel a great deal of distance, which will really preclude some of our elderly from tolerating certain types of surgery on outpatient basis.

Is there something that can be done in these cases? Are there exceptions to the rules where they could have outpatient surgery on an inpatient basis? Can they appeal in those categories?

Ms. KOCH. Yes. Let me say first that what was given in my testimony for the three HMO's were their corporate addresses. Two of those three, the Maryland IPA and Health Plus, now operate in Frederick County. I do not at the present time believe any are operating in Allegany County, Washington, or Garrett County, but the independent practice association model of an HMO is one that lends itself most easily to rural settings, and we are very enthusiastic about seeing HMO's develop in rural areas.

As to moving the service to an outpatient setting, that is not something that is forced by a mechanical kind of decision that, for example, every single intraocular lens operation will be performed in an outpatient setting, even though they can safely and effectively be.

Yes, the patient's location is taken into consideration. The patient's condition is taken into consideration, and the patient's physician has a great deal to say about that. Admittedly he may have to consult with the PRO in having it done on an inpatient basis, but it can be done on an inpatient basis.

Mrs. BYRON. I have no further questions, Mr. Chairman.

Mr. BONKER. Ms. Koch, you state on page 2 in just commenting on the national program that the average length of hospital stay has dropped as a result of implementing the prospective payment program and is now down to an average of 8.2 days for urban hospitals and 6.7 days for rural hospitals.

Why is it that the average stay in rural hospitals is much shorter than the average stay in urban hospitals?

Ms. KOCH. Mr. Chairman, the average length of stay historically has varied both across the country and between urban and rural areas. Traditionally it has been higher on the east coast, lower on the west coast. It has traditionally been higher in urban areas than in rural areas, and the decline in length of stay has been seen somewhat uniformly across each of those.

The reasons, and it gets to the availability of—at least I believe it gets to the availability of some very high tech services in the urban settings, that in many instances the urban areas are the locations of major teaching institutions which are admitting a wide variety of patients from very wide service areas, and so their lengths of stay tend to be a bit longer.

Mr. BONKER. Does that mean that people in rural areas are getting less quality care because they are moving through the hospitals more quickly?

Ms. KOCH. No. It means that for the same condition and the same clinical status, the patient in the rural area and the urban area may very well be proceeding through the hospital in roughly the same length of time. The urban hospitals have a higher concentration of people who are staying longer. That gets back to the urban——

Mr. BONKER. This is rather simplistic, you understand, but it seems to me that people in the rural areas may be helping to underwrite the higher cost, lengthier stays than urban areas. That is a rhetorical statement. You don't have to answer it.

Let me ask you about your statement concerning PRO's on page 8. In the statement under your comment, you point to the positive developments, the shorter stay time, the incentives for hospitals to be more economical and more efficient in their programs, and so forth. But there has got to be a flip side, and the flip side is possibly the premature discharge of patients in order for hospitals to achieve their profit levels. And, of course, we in the Congress are going to have to deal with this at some point when we have more information.

I might add there are several major studies now underway to see how this new concept is being played out in length of stay and whether or not patients are being discharged earlier than they should so that hospitals can maintain their profits levels.

In any case the one check in place is the PRO, the Peer Review Organization, because that is on the spot and they are hopefully monitoring these developments to make sure that patients aren't being denied hospital care.

You say that because of strengthening legislation in the 1982 act that PRO's now have the authority to deny payment for poor quality care.

Ms. KOCH. Yes.

Mr. BONKER. Then you go on to the next page and say that if the review organization finds poor quality, corrective action will be taken. This is even under the program you have with the Maryland program that is unique for this area. The PRO could also take steps to educate the individual practicing physician in the hospital involved, and if necessary ultimately exclude Medicare payment when appropriate. These are very tough enforcement checks, if you will, against hospitals who might otherwise deny patients their care.

Now, my question. Is the PRO made up of practicing physicians?

Ms. KOCH. For the PRO, there are several models of physician sponsorship or physician access. Yes, the PRO is a reflection of practicing physicians in that locality.

Mr. BONKER. So, in that local community where you have possibly one hospital to which all the doctors are performing their surgical work, and so forth, how can they look at something like this objectively? They certainly wouldn't want to recommend a denial of payment or even shutdown of Medicare reimbursement to the only hospital in the community.

How objective and how effective can a PRO be if they have potential conflicts of interest among their colleagues in the community and perhaps one or two hospitals? Is this really an effective check?

Ms. KOCH. I believe it is an effective check, perhaps the most effective check that we can construct. The PROs are statewide organizations and the legislation does not require that they be a local organization, as they are right now. The likelihood of the individual community hospital, or the individual physician in a given location being able to strongly influence the decisionmaking of the entire peer review organization is, I think, remote.

Secretary Bowen has been quoted as saying that doctors simply have to become more active and more involved in policing their own organizations because they are, in fact, the only people who

can. It is difficult to envision a medical review activity conducted by other than physicians.

Mr. BONKER. These may be unfair questions. I am just curious as to how the program works, and incidentally, you didn't set up the program, Congress did. But we need to know how these things work out here in rural America.

You say that in all cases where PRO finds poor quality, corrective action will be taken, ranging from education of the individual physician and the hospital to intensified review and ultimately to the exclusion of Medicare program when appropriate.

In the short period in which this program has been in effect, can you think of any instance where corrective action has been taken?

Ms. KOCH. There are numerous instances of corrective action in terms of the education of the individual facilities, and particularly in terms of record review. I would suggest now with the enlarged scope of work and the new generic quality screens, you could take as an example, the incidence of hospital-induced infection, in a hospital setting.

Recognizing that in the hospital, the PRO's first step is to go to that hospital and work with them to correct whatever, their infection control procedure, for example, in order to eliminate that problem. The next step where a pattern of low-quality care is perceived, or for example, a pattern of premature discharge might be perceived, and these have been rare, is to recommend to the office of the inspector general a sanction action against that provider which would eliminate them from the program.

That is an extreme action and it is one that we do not take very lightly or very frequently because of its extreme nature.

Mr. BONKER. Well, we have in this area the Garrett Community Hospital?

Ms. KOCH. Yes.

Mr. BONKER. Are you saying that the PRO consists of doctors that are pretty much outside this area, or combination of doctors outside and inside who conduct these regular reviews of inpatient treatment and release?

Ms. KOCH. The initial review of medical records is conducted by usually a nurse professional with a peer review organization. Where they believe they have a finding, it is referred to a PRO consultant physician. I am afraid that I do not know the Maryland Peer Review Organization's entire list of physicians or to whom they might refer it. It could be outside the area.

Mr. BONKER. Well, as a Federal agency that is in this unique arrangement with the State of Maryland, how do you insure that original intent of the law is adhered to or that the review procedures are carried out, as Congress intended? Is this a joint venture, or do you oversee their administration of the program? Is this the only State in the country in which we have this unique arrangement?

Ms. KOCH. No, there are PROs in every State in the country. The uniqueness of the Maryland Peer Review Organization contract with us has to do with what they have set out as their objectives. Their objectives are tailored to the design of the State reimbursement system. So there are PRO's in every State. The Maryland one looks a little different, that's all.

We contract with the peer review organizations and so we are not in a joint venture in the manner that we are doing review at the same time that they are doing review. We do have a number of mechanisms for overseeing the work of the PRO's and overseeing those contracts.

One is by going behind some of their review activities, doing onsite visits to the PRO, reviewing what they are doing, how they are doing, what their results are. That is done out of the regional office. Each PRO has a project officer and we have several nurse reviewers who go behind the medical review.

There is also a national contract with Systemetrics to review the entire PRO operation, and it has come to be known by the name Super PRO, and their charge is to, in fact, go in to each PRO during the contract period and compare review results.

Mr. BONKER. Let me ask you a question and we are prolonging this part of the hearing, but when you say you have contractual arrangements with PRO's, how are PRO's then developed? How are they constituted so that you have developed this contractual arrangement? You have got two parties. One would be the State of Maryland, or their agency, and then the other would be the PRO?

Ms. KOCH. Yes.

Mr. BONKER. Well, how is the PRO established?

Ms. KOCH. Some of them were existing entities. They were spun off of PSRO's.

Mr. BONKER. Who appoints the doctors who serve on a local PRO?

Ms. KOCH. The PRO is not appointed. In many cases the local medical societies formed a group.

Mr. BONKER. All right. We are talking about the local medical society. In effect, they develop this PRO. Do senior citizens, or do outside groups have any influence whatsoever in how the PRO is constituted?

Mrs. BYRON. In other words, the medical society says, OK, this year, or this 2-year period, it is your turn to serve on the PRO.

Ms. KOCH. No.

Mrs. BYRON. Is it revolving on is it a permanent person that serves?

Ms. KOCH. It is a permanent organization, as the professional standards review organization.

Mrs. BYRON. I understand it is a permanent organization. Does it have a rotating membership?

Ms. KOCH. It has a board of directors which in many cases includes consumer representation. It has an executive director, which is professional staff hired by that board of directors. The nurse reviewers are professional staff, hired by the PRO, working for the PRO. There are some physicians working directly for the PRO, hired, with salaries paid by the PRO, and others that are serving on a consultant basis.

But it is not an instance of a local medical society saying, Dr. X, Y, and Z, this year you are going to be the peer review organization.

Mrs. BYRON. Let me ask you, the PRO has the authority to deny payment for poor quality care?

Ms. KOCH. Yes.

Mrs. BYRON. If they deny payment for poor quality care, does a Medicare patient have to pay or does the provider of the service absorb the cost? What happens in that kind of a case?

Ms. KOCH. The Medicare patient does not have to pay. The provider of the service would absorb the cost.

Mrs. BYRON. The provider of the service would absorb the cost.

Mr. BONKER. Well, again, Congress is responsible for setting up the program, but I am just a little suspicious when we have basically the local medical society being set up to check, monitor and ultimately deny payment to their own group. I mean, you have got to have some kind of representation.

For instance, if beneficiaries or patients feel like something has gone wrong in the system, do they have any appeal? I mean, they go to the local PRO that consists of this network that is all integrated with the local medical society, the medical system, not just the doctors, but everybody who has a stake. If you are going to deny payment or take harsh corrective action, it is an affront, and could potentially harm the economic interest of this little infrastructure.

I know you didn't set it up, we set up the program, but I have got to ask these questions. What kind of honest check do we have on abuse of the system?

Ms. KOCH. Mr. Chairman, the appeal right for a Medicare beneficiary in terms of the coverage of the service and medical necessity of the service exists as it did prior to the development of the peer review organizations.

Indeed, under the previous design PSRO's had a more limited authority but were performing similar sorts of functions. Appeal rights were there. The reason for the Super PRO contract is to terminate, to look behind that PRO contract and get rid of peer review organizations that are not conducting——

Mr. BONKER. Well, in this area, who could replace the existing organization?

Ms. KOCH. Well, under the law that is a competitive bidding process, if it is terminated. It is not required that it be a medical community from within the State. It is not required that it be a local physician organization. It could in the extreme case be an existing peer review organization in another State.

Mr. BONKER. Well, the concern here is that you have got one very sizeable economic interest, because medical care is a big cost factor, as we all know.

And number two, you have health care, which is of vital importance to the people in this room. We just have to make sure that there is an effective check, so that we don't have abuse and we also have efficiency in the program. I think one way to insure this is to have consumer participation and some oversight responsibility, otherwise, it is going to be in-house.

I mean these as rhetorical statements, you don't have to answer.

Ms. KOCH. I would agree. The level of consumer participation is obviously a question. There are now consumer representatives on the boards of directors for most PROs.

Mr. BONKER. We will find out in a few moments whether we have consumer representation on the local board.

Thank you very much, Marilyn Koch, for being here and providing testimony today.

Ms. KOCH. Thank you.

Mr. BONKER. We shall now call the second panel to the witness table. Dr. Karl Schwalm, and Mrs. Norma Bolding. She is the director of the Garrett County Home Health Agency. Dr. Schwalm is the director of medical staff at the Garrett Community Hospital, and they will be accompanied by other witnesses as well. I hope we have enough chairs.

Dr. Karl Schwalm, is that pronounced correctly?

Dr. SCHWALM. That is correct.

Mr. BONKER. Good; we are off to a good start. Why don't you begin, and then followed by Mrs. Norma Bolding with the health department here in Garrett County. Please, you may proceed.

Dr. SCHWALM. I am going to read my speech.

Mr. BONKER. Yes; for all witnesses, move that mike up close and speak loudly and slowly so that people can hear.

PANEL TWO: CONSISTING OF KARL SCHWALM, M.D., DIRECTOR OF MEDICAL STAFF, GARRETT COUNTY MEMORIAL HOSPITAL; NORMA B. BOLDING, R.N., DIRECTOR OF HOME HEALTH AGENCY, GARRETT COUNTY HEALTH DEPARTMENT, ACCOMPANIED BY MARGO VANDIVER, DIRECTOR, GARRETT COUNTY AREA AGENCY ON AGING; LUCY BURNETT, R.N., UTILIZATION REVIEW COORDINATOR, GARRETT COUNTY MEMORIAL HOSPITAL; LARRY BECK, ADMINISTRATOR, GARRETT COUNTY MEMORIAL HOSPITAL; AND BARRY CONGER, D.D.S., OAKLAND, MD

STATEMENT OF KARL SCHWALM, M.D.

Dr. SCHWALM. This speech will not be quite as sophisticated as the last one. I hope that by some specific examples we can point out problems that we have concern for. The two speeches will be divided into my part, which is mainly medical, hospital and dental, and Mrs. Bolding's, which is mainly community based.

We come here today not to condemn the Government or our Medicare Program. We generally concur with measures to cut costs, particularly where there is waste. No doubt the Medicare Program has been overly charitable in past years, and steps that have been taken to save money and to work more efficiently are not in all ways detrimental.

One of the concerns our hospital and physicians have is that criteria for acute hospital stays are blanket criteria, based solely on physical criteria. They make no consideration for social situations, age of the patient and complexity of the patient's care.

To illustrate the problem of social problems; as an emergency room physician I saw a 67-year-old man who was brought to the hospital by two church members at 10 p.m. on a Friday night. He was in a weakened condition. He could not get water because of frozen pipes nor wood for his stove heat. There was nothing on physical exam nor in his history to warrant hospitalization by Medicare acute care criteria. Yet, this man was sick, had no family to care for him, and had no heat or water at home. There is no place in Garrett County to send such a person temporarily. He could not be placed in a nursing home and there is no community shelter to

take such people in Garrett County. This man was admitted to the hospital for 2 days to work up his illness and until other arrangements could be made. The hospital was not paid. If I had followed strict criteria I would have turned this man away, left the burden to his caring neighbors. Perhaps the neighbors might have left this man in our emergency room, in which case we would have at least been forced to care for him, overnight anyway.

A second problem of reimbursement is the complexity of care. Many elderly patients have multiple problems, yet only the most serious is usually considered when length of stay is calculated. A 65-year-old woman in relatively good health who requires uncomplicated gallbladder surgery is not in the same situation as a 90-year-old man who has had three heart attacks, has congestive heart failure and bad lungs and requires gallbladder surgery. Yet for all practical purposes these two people are viewed the same as far as how long they have to recover in the hospital.

There are other examples of multiple processes. The man who had surgery for cancer of the bowel must have a partial bowel removal and a temporary colostomy. Incidentally, at his surgery it was discovered that this man has gallstones, which should be removed. When this man has his bowel reattached, Medicare would not pay for the gallstones to be removed at the same time, even though it would have saved the man a surgical procedure, a hospitalization, and a great deal of time, money, and physical pain and risk.

Recently Medicare has begun denial of payment for emergency room visits. It is possible in most cases to calculate whether a patient meets admission acute care criteria. It is next to impossible to triage the elderly in an emergency room setting to meet the same acute care criteria. Old folks don't always have fevers and they frequently don't have overt signs and symptoms of severe illness. To turn them away at the door is extremely risky, and some will suffer for it. I have no doubts about that.

Another concern in Garrett County is the lack of skilled nursing home beds. To ship these people out of the county is a hardship on the patient and the family. Our hospital has investigated the possibility of implementing a swing bed program, whereby beds could be used as acute care beds or skilled nursing home beds. We have the nursing personnel and would have very little logistical difficulty setting this up. But, due to the State's methodology for calculating the need for nursing home beds, which does not adequately differentiate the need for skilled nursing care, the planners have indicated that additional nursing home beds are not necessary. As well, the State planners have taken a very negative approach to the swing bed concept, especially concerning our hospital.

We have concern regarding hospice, a program which is largely volunteer staffed, designed to help terminally ill patients and their families cope with the final days, weeks or months of life. One aim, where possible, is to encourage hospice patients to be cared for in the home. Yet there comes a time when families cannot cope in one way or another, when the patient needs some skilled nursing care such as that available in a nursing home or hospital. Often these patients do not meet strict Medicare acute illness criteria,

and I am fearful that the Hospice Program will suffer without this support.

Finally, I would like to mention how our geography and climate affect our Medicare patients. Our patients come as far as 35 miles over mountainous roads for a visit to a doctor or dentist's office. Particularly, our elderly patients have difficulty in midwinter getting to and from the hospital. They often cannot get out of their driveway, even if the road is plowed. There is no public transportation. We often feel compelled to keep an elderly patient that extra day to make sure recovery is well on its way, because if the patient goes home and has difficulty with his illness, it may be no simple matter to return to the hospital.

Our Medicare reviewer, Dr. Yaffee, made it quite clear to us here in person, that under current guidelines he can make no allowance for such situations. Alternative means must be found, and unfortunately, in Garrett County, the resources and possibilities are more limited than in Baltimore or Washington, DC.

Medicare patients, in general, do not understand their benefits or responsibilities. The burden is put on the physician and hospital to explain the ins and outs. If admissions or days are denied, the physician and hospital lose. This is a one-way street.

In summary, we welcome Medicare's attempts to be more efficient and to cut waste. We have tried to emphasize the points at which this cost control program has cut benefits in an adverse way to our patients. We would like some reconsideration or ongoing consideration as the Medicare Program evolves.

I am now going to read a statement written by Dr. Conger.

Mr. BONKER. Dr. Schwalm, why don't we have that just submitted for the record?

Dr. SCHWALM. All right.

Mr. BONKER. Does that conclude your statement?

Dr. SCHWALM. Yes.

Mr. BONKER. I was just struck by something in your statement. You stated on page 1, that as a medical director for the hospital, you were faced with a situation involving a 60-year-old man, that had you followed the "strict criteria," you would have turned him away.

Dr. SCHWALM. That is correct.

Mr. BONKER. Well, how do you know when a person comes in in a situation like that, especially if it is an emergency, what form of coverage will be involved? In other words, he is an individual that may or may not have independent means to cover his cost. He may or may not have insurance that would cover his medical cost. He may or may not qualify under Medicare, which apparently was the basis for your concern here. Lastly, if he is truly indigent, in other words, if he has no economic means nor proper coverage, then he would qualify under Medicaid, would he not?

Dr. SCHWALM. That is correct.

Mr. BONKER. Then why would you make a statement that you would look at this person and say, "I don't think he has the proper coverage to cover his medical expenses. I would have to turn him away." I am surprised you would even pose that question when he is coming into the emergency room.

Dr. SCHWALM. As a physician I wouldn't turn him away. What I am saying is Medicare denied this patient a stay in the hospital.

Mr. BONKER. Well, how do you know? I mean, if he isn't properly covered by personal means, or insurance, would he not be covered under Medicaid?

Dr. SCHWALM. Medicaid also has acute criteria. What I am saying is that this patient didn't meet acute criteria. But he had no other means.

Mr. BONKER. Were you there when he arrived?

Dr. SCHWALM. Yes.

Mr. BONKER. You were?

Dr. SCHWALM. Yes.

Mr. BONKER. As medical director?

Dr. SCHWALM. We are a small hospital, and we wear many hats.

Mr. BONKER. I understand, but are you in a position where you are asking people basic questions about the extent of their coverage as a means test for being admitted?

Dr. SCHWALM. Absolutely not.

Mr. BONKER. Then why do you make a statement like this, because you say on the other page, "To turn them away at the door is extremely risky, and some will suffer." Are you turning people away at the door?

Dr. SCHWALM. I was an emergency room physician at the time this occurred. I was not acting as medical director. Medicare asks us to go through the criteria and see, do they have a fever, do they need certain antibiotics, do they need certain things, and if they don't, they are not going to pass. Now, we will still admit them if we feel they need to be admitted.

Mr. BONKER. Well, that is the basic point. You are not going to be turning people down?

Dr. SCHWALM. No; we do not turn away people.

Mr. BONKER. You imply by this statement that you had to make a judgment of whether or not they were properly covered by Medicare or some other source before they were going to be admitted.

Dr. SCHWALM. What happens in marginal cases, though, is that people may get turned away. You have many things to consider when you admit a patient and hopefully the physician always considers only the patient, but when the hospital is having a hard time and people are not getting paid, this is always in the back of your mind.

Mrs. BYRON. Weren't you really looking at whether the patient should be hospitalized or not, regardless of whether he had insurance or not?

Dr. SCHWALM. That is correct.

Mrs. BYRON. You were looking at the criteria which you have to operate under as a physician about whether this person should be hospitalized. Should we use the bed for an individual that really would not be a chronic critically ill individual. This is what I find very, very difficult to understand and the flexibility, I think we are taking away from the physician, when they know a home situation, for example, of an individual who has had some surgery. In a lot of cases, the individual could go home to an area where maybe there was an individual there who had some nursing care or some skilled care background; as opposed to an individual who is a senior citi-

zen and is going home to a husband or a wife who is also a senior citizen and without skilled care capabilities. They are without the physical capabilities of monitoring and maintaining medication, changing dressings, and these types of issues.

I think these are the things that really concern me, the flexibility we are losing by a physician not being able to make that decision.

I think the point you were trying to make was the flexibility of a physician to admit a patient because he know a home situation where there is no one there, and there is no alternative other than admitting the patient, as opposed to the pay cost. Am I correct?

Dr. SCHWALM. You are correct. I have apparently given the wrong impression. I don't think any, or very few physicians, are going to look at the insurance and say, well, you can be admitted or you can't be admitted.

Mrs. BYRON. I think in the case you cited, you were really looking at the history, the case history, of an individual that has, no heat, no water, and is physically unable to really care for himself. At the same time, he is not in a critical state, but in a state of emergency.

Dr. SCHWALM. That is right, and the problem is, when you look back at it, that is when it is denied. Beforehand, most of the time we don't even look at what the insurance is. But if an elderly person comes in, you are always under this cloud that you may or may not get paid, whether or not you admit them.

Mrs. BYRON. Well, do you think the Federal Government is responsible for the lack of understanding of Medicare benefits among our senior citizens in general? This concerns me, because many of our senior citizens really do not understand what benefits there are and what benefits are available.

Mr. BECK. If I could, for a minute. I am Larry Beck. I am the administrator of the hospital, and I do have a couple of comments about the problems that are faced by the physicians and the hospital on a day-to-day basis.

I think we have to get an understanding of how pervasive these utilization control programs, the PRO, professional review organization, really are. Most of their objectives are not geared to quality. They are geared to quantity. Almost 90 percent of their mechanisms are geared to controlling the quantity of care, and therefore, obviously the dollars that flow into the system.

For example, even in Maryland, the target goal for the PRO was to reduce expenditures by some 11 to 15 percent for Medicare, and very little of their objectives, maybe one to two that I can think of, have anything to do with quality at all, and they don't shoot for quality.

Mrs. BYRON. Does the physician have any discretion in determining the hospital stay of a Medicare patient or is it just kind of locked into a formula?

Mr. BECK. What I advise my physicians to do is, do what is medically necessary for the patient, what you feel is appropriate qualtity care. We do the fighting afterwards, in terms of fighting with Medicare or PRO.

Mrs. BYRON. Take care of the patient and we will worry about it later?

Mr. BECK. Correct. The problem with that is, it was mentioned earlier, flexibility in the system. Yes, you can pick up the phone and call. Surgeons on our staff have done that and the answer usually is, no. They apply urban standards where there may be other facilities, other services available. They say, no. Can we bring this elderly gentleman in because he is too much of a risk to bring in for outpatient surgery. They say, no. There is no flexibility.

Mrs. BYRON. Yes, I have been meeting on a regular basis—I have been in seven different counties and I have met with the medical societies in several of those counties. There is a great diversity in the type of care that is available in various communities. The one that concerns me so much is the rural community, because there are no other alternative services for that individual on that basis. And so, that, in your mind, constituted an emergency.

Mr. BONKER. Sorry for the diversion. We will get back on track with Mrs. Bolding. We have a rather animated discussion going, Mrs. Bolding. If you wanted to submit your written statement and just comment informally, you are welcome to do that, or you can proceed and read your statement. What is comfortable for you?

STATEMENT OF NORMA B. BOLDING, R.N.

Mrs. BOLDING. I would rather read my statement.

We express our appreciation for your interests and concerns for the problems of the senior citizens of Garrett County.

As you are aware, Garrett County is the westernmost county in the State. Situated on the other side of the Eastern Continental Divide, and at a higher elevation than other Maryland counties, we face more severe winter conditions through the year. Dense fog and deep snows are no strangers, and while they provide barriers to young people, they actually isolate the senior population. Of the 47 percent of seniors older than 65 and still licensed to drive, many hesitate to travel under difficult conditions, and since over 62 percent of the seniors live outside a township, they often are incapable of shoveling out to a paved road. Neither is it unusual for a senior in need of medicine to face a 50-mile-round trip to one of the seven county pharmacies.

Garrett County has a population of nearly 27,000 people with one-fifth or approximately 4,700 of these over 60 years of age. Twenty percent of these elderly persons live below the poverty level of $4,500 annual income.

Although recent budget cuts have not affected Social Security payments to the elderly, the coinsurance needed for hospital payment certainly has. Within the last 10 years, coinsurance has risen from $90 to $492 for the first hospital stay within a given year. To many Garrett Countians, this in itself may be a barrier to even seek medical care. Many do not have a supplementary insurance such as Blue Cross and Blue Shield or they have purchased inadequate types which are worthless with the now imposed early hospital discharges. There is a lot of confusion with all types of health insurance, including Medicare. Some seniors are afraid to spend money for any health care unless they are acutely ill.

To meet eligibility criteria for Medicare, the beneficiary must be confined to his or her home under the care of a physician, and the

intermittent care must be reasonable and necessary to the treatment of the individual's illness or injury. Services directed to the prevention of illness or injury are not covered. This comes straight out of the provider Medicare manual.

Due to Garrett County's sparse population and mountainous terrain, the Garrett County Health Department offers the only home health agency, operates the medical assistance Personal Care Program, the Geriatric Evaluation Program, and is the outpatient component to the county's Hospice Program.

The Home Health Agency serves some 120–140 clients monthly. Reimbursement for services is received from Medicare, approximately 70 percent, with the remainder from Medical Assistance, private insurances, cash payment according to the patient's sliding fee scale, and of course, we have the no pays.

As with all Government agencies, our Garrett County Health Department Home Health Agency is really feeling the funding cuts. Medicare reimbursement has dropped from 92.2 percent to 80 percent of total costs this past year. Another 1-percent deduction is expected for medical supplies due to the recent Gramm-Rudman law.

Justification for home health care is becoming more stringent especially with the fiscal intermediaries, Blue Cross and Blue Shield, Inc. of Maryland, placing new interpretations on Medicare laws. Agency costs continue to rise due to transportation costs, medical supply costs, and gear up expenses to meet the new high technology challenge. Medicare is forcing the intermediary to deny payment for home visits if they interpret the need for medical care was not sufficient or that the client was not homebound.

An example of this is a chronically ill, bedfast diabetic patient can be denied payment for services if all he or she needs is a blood test every month to check his or her insulin needs. If the medication is not adjusted monthly and the intermediary, Blue Cross/Blue Shield, considers the patient's condition has plateaued, reimbursement for home visits are deemed no longer necessary regardless of this being a high-risk patient.

In the past, a provider agency could seek a reconsideration for payment denials, but HCFA has now considered this unnecessary costs.

I would now like to introduce Mr. White, and just by his attendance here today, he no longer qualifies for home health care via Medicare because he is more or less breaking the homebound rule. Mr. White is fortunate to be one of the few to be able to afford a supplementary insurance as well as having Medicare benefits. Last October 1985, he was hospitalized with a malignancy with necessitated surgery and the removal of 90 percent of his small intestine as well as leaving him with a permanent colostomy. Five years ago, Mr. White probably would have had to spend the remainder of his life in a hospital-type environment for his intravenous feeding or died of malnutrition. Although Mr. White spent 2 months in the hospital with a total cost of over $27,000, he was happy to come home after a high technology procedure, that of a semipermanent venous catheter which was threaded under the skin into the large blood vessel going into the heart, was performed. This enables his wife, who has done an excellent job, to administer his all night IV feeding solution at home. Mr. White has been able to stay at home

with home health teaching, assessments, and support to his family. Medicare has paid for most of this supplied through the Home Health Agency. Since Mr. White is gaining weight and recovering to the point where he is no longer homebound, he will have to be discharged from the Home Health Program and will need to find an alternate source for payment for his care.

Many other Garrett Countians without Medicare and coinsurance would have had to spend their life savings and home to maintain the level of care his condition warranted. Medicare/Medicaid does not provide for those patients that are chronically ill needing only minimal services. Nor does it take into consideration for psycho-social-environmental factors. Mr. White's surgeon is in the Cumberland area and the approximately 60-mile drive is often an impossibility in severe winter conditions.

Medicaid and private insurance companies tend to follow Medicare's lead in regulations and eligibility requirements.

In rural Garrett County, the elderly community is mainly made up of farm families with little community resources. Such absence of available resources is not prevalent, not long tolerated in an urban area. Community groups and private organizations spring up to meet the need. However, in this country with unemployment hovering at 13 percent, so few individuals are able to pay a going rate for in-home services that private enterprise does not have much chance. The one chore-service agency which opened in 1984 closed quickly as not enough clients could be found to afford even moderate fees for in-home services.

The most recent series of budget reductions spurred on by the Gramm-Rudman-Hollings legislation has not improved the situation. Throughout the past year the area agency on aging has relied on the health department to encourage the seniors to participate in preventive medicine or Wellness Together Programs. The Health Department nurses were very supportive in visiting meal sites, addressing dietary concerns, monitoring blood pressures, and performing minor diagnostic and screening procedures. Additionally a minihealth fair at each site was held as was a subsequent flu clinic.

This year we will see little of this support because of the lack of funds. The AAA staff will continue to promote Nutrition Slide Programs, exercise sessions, and updates on new medical findings and developments. However, the seniors already miss the nurses' visits to the sites, and nurses are able to make a difference through their visits. Participants are encouraged to visit their physician when a problem is uncovered. Specifically because of transportation and economic concerns, many seniors have not received routine health care, nor had a checkup for years. Many recognized conditions were discovered during the nurse's site visits, which in some instances saved lives as well as acute care dollars.

Therefore, in this county of 662 square miles, we do not have a well rounded preventive medical program nor much assistance for noneligible Medicaid patients who have a health problem for which there is no cure or chance of improvement.

This is how we differ from a metropolitan area. We do not have a great variety of resources now, not even the fundamental services available to meet the important health care needs of our senior citizens.

In 1986, and beyond, we are facing a very significant growth rate in the senior population. Unfortunately, as we have watched the growth of seniors 65 years and older increase to 12 percent of the population, we do not have even the beginnings of a support system in place.

Additionally, we have significant problems in housing seniors who receive only the minimal SSI allotment. Where does an individual live outside of a nursing home when only $350 per month is received? In our community we have 80 units of senior housing, but the individual needs to be in good health to reside in the congregate setting. In such residences many seniors are isolated due to the lack of activities. Also they are fearful of having to move if they are no longer healthy.

If a senior is losing his eyesight, or facing a very slow yet debilitating illness, they currently do not have the choice of moving to a foster home which is affordable. Instead they move into the nursing home years before it may be medically necessary, solely because the State will finance care.

As health care providers, we are charged with the responsibility of looking at the total person, not just the disease entity. It is that continued emphasis that is placed on hospital personnel as well as community health personnel to help the recuperating, the chronically ill client to regain as much of his functional capacities as possible. Community resources where the client or family can seek help is reviewed by the health professional and referral is made. In Garrett County, few support services are available and the family unit is still the center of care. Garrett County does not have an adult day care center to provide respite care for the client living in a home with working family members. Again, many are forced into nursing homes when only limited services are needed to keep them in their own homes. The existing Garrett County Geriatric Evaluation and Referral Program is also curtailed in its service to the elderly due to lack of community resources.

So our recommendations to you then are: one, extend funding for community resources and thereby cut some of the high costs of acute hospital stays or nursing home placements. A. This could be accomplished by extending Medicare/Medicaid benefits to meet the chronically ill needs, not just acute care presently covered by home health agencies. A bimonthly or monthly visit by a community health professional could detect an early localized illness, requiring a telephone call to the physician or an early visit to the private medical doctor instead of letting it develop into a systemic acute illness requiring hospitalization. To most of our proud elderly, particularly those near or below the poverty level, it is hard to find even the money for the basics of food and shelter. A visit to the doctor is out of the question.

B. Extend payment for personal care or chore services in the home, such as home health aides for bathing, meal preparation, et cetera. Sometimes all that is needed to keep the elderly in the home is a sitter or someone to fix a noon day meal for an elderly person, while the rest of the family is at work.

Two, encourage startup funding and support for day care centers and with less restrictions. Current Medicaid payment in day care centers require regular attendance. In Garrett County's uncertain

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weather conditions, clients would not participate on some days in the dead of winter whether they could pay or not.

Three, provide extended funding for health promotion and prevention of illness. Encourage Medicare/Medicaid and private insurance companies to pay for yearly or prescheduled checkups for early detection and prevention of serious illnesses. This could be done with geriatric evaluation centers geared to assessments, referral to private medical doctor for treatment and followup and teaching to the seniors and families regarding coping mechanisms for chronic illness. In the long run this may even cut costs of state institutions, care of some mental illnesses, alcoholic treatment centers and drug abuse in the elderly.

Unless we are to become a Nation that practices social Darwinism, that of only the survival of the fittest with the most money to pay for health care, we all must learn to use our resources for self care and become better health consumers. Or are we willing to permit senior genocide? And at what age and where will we draw the limit? 90, 70 or 50?

As a society, we are only beginning to come to grips with some of these problems. By the year 1990 it is estimated that 50 percent of our population will be over the age of 50.

If at that time, a high proportion of these citizens are in nursing homes, we are in serious trouble. So let's make sure that we insure a healthy senior population. As we have seen at the age of 60, many people still have 40 more years in which to interact, love and lead productive useful lives.

To keep the Nation viable, we need to keep all our citizens viable. This can be accomplished only by keeping them as healthy and productive as possible. Presently in Garrett County, we are unable to support our present senior citizens through an integrated health system.

Our hope for the future is that each Maryland senior resident has access to these fundamental health care services necessary in promoting independent living rather than be faced with institutionalization.

Thank you.

Mr. BONKER. Thank you, Mrs. Bolding. The other witnesses are more or less backup to the panel, but I would like to call upon the resident dentist here, Barry Conger, who has a formal statement for the record. Since I have seen some signs out here about dentists and health care under Medicare, and given what I have read in his statement already, that dental care, at least under the existing Medicaid program, is a myth, I thought this would be a good opportunity to clarify what the Medicaid/Medicare offers and how the dental community is moving to meet some of these needs.

Dr. Conger.

STATEMENT OF BARRY CONGER, D.D.S.

Dr. CONGER. Yes, I would like to go ahead and read my statement. It is very short, if I may.

Mr. BONKER. I love short statements, so you may proceed.

Dr. CONGER. Thank you.

I would like to address several points on the Medicare/Medicaid system. While it is understood that the State cannot expect the taxpayers to provide and support comprehensive complex dental treatment to Medicare/Medicaid patients or recipients, many areas of very basic dental services are not being met or addressed.

We must clear up one point before we can proceed. The Medicare/Medicaid system now covers only emergency dental services, as an example, extractions or acute infections. One must not be mislead that this is dental care. This is only supervised dental neglect. Time and time again we hear and read in literature that our nursing homes deliver care or that legislators state that basic dental needs are being covered by the Medicare system. The term dental care cannot be used in its present Medicare system, for it is myth.

Dentists are being placed in unjust situations with regard to many nursing home patients. Patients are being seen only after they have verbalized specific tooth pain or oral pains. In most, if not all, instances, there have been no screening, nor even the most rudimentary exams performed previously. No radiographs are available, nor are they obtainable in most nursing home facilities, yet the dentist is asked to treat this patient.

Many times a routine dental filling may be all that is required. However, reimbursement is granted only for an extraction. In some instances, a root canal can be done on a front tooth, but again, extraction is the only reimbursable treatment available, further depressing the elderly Medicare/Medicaid patient, and eliminating his or her smile. As a result of this premature loss of teeth, many patients are placed on mush diets. These mush diets then result in nutritional complications and could have been avoided if teeth had been saved.

Although I cannot find a study to back up this theory, I truly believe that many, many hospital admissions, treatments for nutritional disorders and long recovery periods from other illnesses could be avoided by providing the Medicare/Medicaid patient with the very basic dental care and not this dental neglect that in some cases is now taking place.

The best implementation of this basic dental care service could be accomplished by placing a dentist or dental hygienist under the supervision of a dentist on a needs assessment team. This needs assessment team could properly screen and evaluate individuals to determine what conditions are present and the best way to correct these conditions.

Providing dental care is not as expensive, it is verifiable, controllable, and cost-effective. The results that can be obtained from nutritional counseling, wellness and prevention programs could be beneficial. In combination with meeting basic dental needs, the anticipated results could truly be outstanding.

Dentistry has led all the professions in prevention, and it has worked tremendously well.

Thank you for letting me read that.

Mr. BONKER. I think it is interesting you note that in some instances coverage would extend to extraction but not root canal.

Dr. CONGER. Yes, that is the case, and again, what Dr. Schwalm mentioned, don't get us wrong in saying that we are looking at pa-

tients and finding the situation, as we have to treat this patient based on what their coverage is. That is not the case.

Many, many times we are seeing that we are put in a position only after the fact that we treated this patient and he is not covered. Is it fair to the physician and to the dentist to then have to go through the review process and be badgered and whatnot after the fact. However, this is not occurring before the fact. I think Dr. Schwalm made that clear. Never is a patient sent out in pain or without the proper, at least, rudimentary care. That is just not being done.

However, as the population increases in the over 65 age group, we are going to have continued problems in, is this au gratis care which is going on now, can this continue at an increased rate as the population ages and as the over age 65, we are finding more and more teeth are being retained in this age group and are going to require, time and time again, more care and more time for dental as well as other services. Thank you.

Mr. BONKER. And it is expensive.

Mrs. Byron.

Mrs. BYRON. I have a couple of points.

Dr. Conger, do you feel that there is widespread unnecessary tooth extraction just because of the reimbursement guidelines?

Dr. CONGER. I feel, as you related to earlier, that in many, many cases, this procedure could have been prevented if it had been picked up 2 to 3 years earlier at, say, what you mentioned, a health check type of program. Sometimes the horse is already out of the barn, so to speak, by the time we get to see them. And from this standpoint alone, a lot of times, yes.

Mrs. BYRON. Let me ask Mrs. Bolding a question. We are finding on payment denials they are no longer being appealed if they have merit. Do you find that more and more?

Mrs. BOLDING. Yes, the home health agency cannot send in materials and so on to the intermediary any more because this is too costly from HCFA's point of view. We can ask the beneficiary to go down to their Social Security office here in Cumberland and file a claim, but most of these people are homebound.

Mrs. BYRON. Yes. Let me make one comment, which I think is one that has not been lost on me today. We have in front of us a group of individuals from Garrett County. For those of you that don't know, Garrett County is a fairly rural county, and it has had the problems that many of the rural counties have, the younger population is moving out of the county. I think this speaks very well for the fact that a younger population is obviously moving back into the county and playing a very strong role in that county's benefit.

I remember Mr. Beck when he was over in Carroll County, and I am delighted to see that he went west, young man.

Mr. BONKER. If you go all the way west, you will end up in my district.

Dr. Schwalm, I would just like to ask a few questions about Garrett Community Hospital, because I know nothing of the institution. How many beds do you have in that hospital?

Dr. SCHWALM. Seventy-six beds.

Mr. BONKER. And what capacity are you now?

Dr. SCHWALM. I am here as——

Mr. BONKER. No, no. I mean how many of the beds are presently occupied?

Mr. BECK. We are running about 70 percent occupancy. About 50-some beds occupied at this time.

Mr. BONKER. Seventy percent?

Mr. BECK. Yes, 70 percent occupancy. That means about 50 to 55 patients on average.

Mr. BONKER. OK. Is that enough to break even, to make a profit? What percentage level do you start losing money?

Mr. BECK. We are under the Health Services Cost Review Commission, which protects through the total patient revenue system.

Mr. BONKER. So you don't have an incentive to fill up the beds necessarily?

Mr. BECK. No; we don't have an incentive to turn people away, either.

Mr. BONKER. Representative Byron would like to know whether that percentage is seasonal or whether that is an annual percentage?

Mr. BECK. It does fluctuate. The summertime is a busy time because of Deep Creek Lake and the resort area. During the winter months, it drops off significantly because the transient population leaves for the winter months. The average is somewhere around 70 percent occupancy throughout the year.

Mr. BONKER. OK. Could you give us just a brief idea in Garrett County how the PRO works?

Mr. BECK. I would be glad to. The PRO actually is centered in Baltimore, which is 3 hours drive away, and it is a quasipeer review organization. Our physicians in Garrett County and pretty much all of western Maryland, really have not been guilty of the problems that have occurred elsewhere in the urban environments.

The average cost per hospital stay in the western Maryland area has been some 30 percent below the urban areas, as well, length of stays have been below the urban areas. So many of the problems that have created the need for a PRO have never been existent in the western Maryland area.

And yet, these organizations still have jurisdiction over us. They are physicians. I have only met one physician of the PRO in Baltimore, who basically set the guidelines and criteria by which patients can, A, be admitted, B, continue to say in the hospital.

Only upon appeals and phone calls, et cetera, can you try to crack this barrier, this criteria. As I mentioned earlier, there is no flexibility. Anybody who says there is, is just not saying it as it is.

Physicians call down and say, "Look, I have got a situation with an elderly patient that requires this, that or the next," and I am talking about very cost-conscious physicians to begin with, and they are denied almost all the time. I can't cite an example where they were not denied a bending of the rule, et cetera. Again, I think it is because the emphasis of these PRO's are financial. They are not quality oriented.

Dr. SCHWALM. I would like to make another point clear. Our medical staff and the medical society, we don't form a part of that PRO, at least locally, we don't, and I was afraid you were getting the wrong impression that we elect somebody and send them down

to the state and then they would make up the PRO. That doesn't occur. I don't know where the physicians come from that are on the PRO, but we don't have anything to do with it locally.

Mr. BONKER. Well, what about area representation that has some oversight or jurisdictional responsibilities here? Is this a Baltimore-based contractual——

Mr. BECK. What they do is each hospital is allowed to have what is called a physician advisor, and you also have your own nurses usually. It is pretty much out of self defense that you do this because you need a physician on the scene who is also simultaneously reviewing this care that Medicare is going to review subsequently. You need a physician advisor to be sure that you are in a position to appeal a medical review and fight it after the fact should it come to a point of denial.

So you will have a physician advisor locally. Basically, it is like asking someone if they want to catch leprosy because nobody really wants to do it, but it is a job that has to be done.

In fact, our physician advisor just resigned because of a lot of reasons, but one reason is the frustration involved with dealing with your fellow physicians in this role of the gate keeper, so to speak. It is a very tough role.

That is the extent of the involvement on a local level of a physician, maybe one physician who can interface between the PRO and the medical staff and basically interprets these guidelines, which are fairly rigid. There is not much flexibility in these guidelines.

Mr. BONKER. Well, that is very interesting.

I want to thank all of you for being here today and helping with our understanding of federal programs and how they relate to Medicare and other health care programs. Thank you for coming.

I understand that Margo VanDiver has a prepared statement for the hearing record, and if there are no objections, it will be included in the record at this point. Hearing no objections, so ordered.

[The prepared statement of Margo VanDiver, director, Garett County Area Agency on Aging follows:]

PREPARED STATEMENT OF MARGO VANDIVER, DIRECTOR, GARRETT COUNTY AREA AGENCY ON AGING

I wish to express my appreciation for your interest in the concerns and problems of the seniors of Garrett County, Maryland. As the Director, Garrett County Area Agency on Aging (AAA), I welcome this opportunity to share some of our findings and experiences with you.

As you are well aware, Garrett County is the westernmost county in the state. Sitting on the other side of the Eastern Continental Divide, and at a higher elevation than other Maryland counties, we face more severe weather conditions throughout the year. Dense fog and deep snows are no strangers, and while they provide barriers to young people, they actually isolate the senior population. Of the 47% of seniors older than 65 and still licensed to drive, many hesitate to travel under difficult conditions, and since over 62% of the seniors live outside a township, they often are incapable of shoveling out to a paved road. Neither is it unusual for a senior in need of medicine to face a 50 mile round trip to one of the seven county pharmacies.

Currently there is not one private health care agency in the community. The Health Department has no restrictions on their services; however under Home Health Services they can only assist acute care patients. Therefore there are many seniors with chronic conditions without medically supervised in-home care health service.

Such absence of available resources is not prevalent, nor long tolerated in an urban area. Community groups and private organizations spring up to meet the need. However, in this county with unemployment hovering at 13%, so few individuals are able to pay a going rate for in-home services that private enterprise doesn't have much chance. The one agency which opened in 1984 closed quickly as not enough clients could be found to afford even moderate fees for in-home services.

The most recent series of budget reductions spurred on by the Gramm-Rudman-Hollings legislation has not improved the situation. Throughout the past year the Area Agency on Aging has relied on the Health Department to encourage the seniors to participate in preventive medicine or Wellness Programs. The Health Department nurses were very supportive in visiting meal sites, addressing dietary concerns, monitoring blood pressures, and performing minor diagnostic and screening procedures. Additionally a mini-health fair at each site was held as was a subsequent flu clinic.

This year we will see little of this support because of the lack of funds. The AAA staff will continue to promote nutrition slide programs,

exercise sessions, and updates on new medical findings and developments. However, the seniors already miss the nurse's visits to the sites, and nurses are able to make a difference through their visits. Participants are encouraged to visit their physician when a problem is uncovered. Specifically because of transportation and economic concerns many seniors have not received routine health care, nor had a check-up for years. Many unrecognized conditions were discovered during the nurse's site visits which in some instances saved lives as well as acute care dollars.

Therefore in this county of 662 square miles we do not have a well-rounded preventive medicine program nor much assistance for non-eligible Medicaid patients who have a health proolem for which there is no cure or chance of improvement.

This is how we differ from a metropolitan area. We do not have a great variety of resources, nor as now, even the fundamental services available to meet important health care needs of our senior citizens.

In 1986 and beyond we are facing a very significant growth rate in the senior population. Unfortunately as we have watched the growth of seniors 65 years and older increase to 12% of the population, we do not have even the beginnings of a support system in place.

Additionally, we have significant problems in housing seniors who receive only the minimal SSI allotment - Where does an individual live outside of a nursing home when only $350 per month is received? In our community we have 80 units of senior housing, but the individual needs to be in good health to reside in this congregate setting. In such residences many seniors are isolated due to the lack of activities. Also they are fearful of having to move if they are no longer healthly.

If a senior is losing his or her eyesight, or facing a very slow yet debilitating illness, they currently don't have the choice of moving to a foster home which is affordable. Instead they move into the nursing home years before it may be medically necessary, solely because the state will finance care.

A few subsidies for community living are being provided for seniors. Certified residences are slowly being created to offer alternative housing at an afford.ble cost. The state now pays approximately $1,400 per month for an individual in a nursing home, when it cost only $200 in subsidies for that same senior to reside in a certified sheltered home.

As a society, we are only beginning to come to grips with some of these problems. By the year 2030 it is estimated that over 21% of our population will be senior citizens.

If at that time a high proportion of these citizens are in nursing homes we're in serious trouble! So let's make sure that we insure a healthy senior population. As we've seen at the age of 60 many people still have 40 more years in which to interact, love and lead productive, useful lives.

To keep the nation viable, we need to keep all our citizens viable. This can be accomplished only by keeping them as healthy and productive as possible. Presently in Garrett County, we are unable to support our present senior citizens through an integrated health system.

Our hope for the future is that each Maryland senior resident has access to these fundamental health care services necessary in promoting independent living rather than be faced with institutionalization.

Mr. BONKER. The next panel will include representatives of Washington County, which is one of the three counties involved in today's hearing. So I would like to call to the witness table Betty Poyner, who is the director of Washington County Home Health Agency, and Horace W. Murphy, who is the president of Washington County Hospital Association. They will be accompanied by Ralph Garver, Anne Mayhew, and Kirkland Brace.

I am hopeful, since we have the panels submitting testimony based on the counties they represent, that we can avoid redundancy. We do have representatives of the various medical troops and some of the testimony can be redundant. If we avoid that, it will help move along the hearing.

We shall begin, I think, as is outlined on our committee agenda. Betty Poyner, who is the director of the County Home Health Agency. Welcome.

PANEL THREE: CONSISTING OF BETTY J. POYNER, R.N., HOME HEALTH SUPERVISOR, DIVISION OF NURSING, WASHINGTON COUNTY HEALTH DEPARTMENT; AND HORACE W. MURPHY, PRESIDENT, WASHINGTON COUNTY HOSPITAL ASSOCIATION, ACCOMPANIED BY RALPH GARVER, DIRECTOR, WASHINGTON COUNTY AREA AGENCY ON AGING; ANNE D. MAYHEW, R.N., CPQA, DIRECTOR OF QUALITY ASSURANCE/UTILIZATION REVIEW, WASHINGTON COUNTY HOSPITAL ASSOCIATION; AND KIRKLAND R. BRACE, D.D.S., HAGERSTOWN, MD

STATEMENT OF BETTY J. POYNER, R.N.

Ms. POYNER. Thank you, Mr. Chairman, Mrs. Bryon. We really do appreciate this opportunity that we have to express our concerns to you for the Medicare Program.

You have my written testimony. In addition to mine, there is a testimony in there from Dr. Kirkland Brace, who is the dentist in our county. I will not read mine, I will summarize it. I will not touch on his, since the needs in our county as far as dental care are the same as for Garrett County.

It was interesting to me, as I read the different statistics for percentage of the elderly, Washington County really is not a whole lot different from Garrett County. We have a population of 110,000 approximately in Washington County; 19 percent are elderly or 60 years of age and older. So because about a fifth of our population is elderly, we really are concerned about what happens to the elderly and to the Medicare Program.

We also do agree with the impetus on the part of the Federal Government to reduce the deficit. We have no argument with that.

The problem that we have, particularly with home health, which is my area of expertise, is the fact that there are already cuts in effect affecting the home health program and the health program as such.

The DRG Program, for instance, is one that really discharged people from the hospital earlier. So it made home care more essential. It seems odd to me that Congress could not see in initiating the DRG system that there would naturally be a rapid increase in home care needs. Yet, because that is happening, they are trying to eliminate or to cut the home health benefit, too.

Actually, another statistic that is not in my written testimony but I would like to bring out is the fact that in 1984, Medicare A and B outlay was $63 billion. Only $2.1 billion of that was spent for home health care. So it really is a small percentage of the actual total Medicare outlay. I guess for that reason, we are a little bit disappointed that there should be some initiation toward the cut in the home care benefit.

For instance, the cost caps were also affecting us already. One thing that has really affected us is the fact that we are already having cuts, as I have stated. Now it seems to us that there is more initiative on the part of our intermediary, who is Blue Cross/Blue Shield of Maryland, to be even more stringent in what they consider to be reasonable and necessary. Very frequently that decision is made arbitrarily by whoever is the reviewer of our records.

One other area that I think has been really difficult on us is in the new forms that we have to fill out, the medical information forms, the 485's, 486's, and 487's. On line 18 on the 486, the question is asked, "Is there available an able, or willing care giver?" If you answer yes in any way on that, then we are going to be denied home health aide visits, which the care giver may not be and usually is not able to give. That is one of our concerns.

Another area of concern that we have, I think, is that there is in Maryland a personal care program which is funded by Maryland Medical Assistance. People who are eligible for this can have a care giver in their home for 2- to 3-hours a day and that care giver is paid $10 a day for her services. But this is only for people who are Medicaid eligible, which means that they have to have an income of somewhere around $300 a month or less. There is a large group of people who are just above that $300 a month that we are concerned about that are not getting the personal care needed. If they were getting their personal care needs met through home care, I really believe that payments for skilled nursing, skilled therapies and so on, would be greatly decreased.

Also, I think we would see less acute needs in these people because when their needs for personal care, for instance, bathing, feeding, reminding them to take their medication are being met, then we can avoid the more costly acute care needs.

One area that I am really concerned with is that Medicare would consider funding a lesser level of care than what they consider to be skilled right now.

Another area of real need in the elderly is the need of nutrition. The hospital is reimbursed for nutrition teaching in the hospital. Because the hospital stay is so much shorter, and it is also not in the patient's own home where the meals are being prepared, it is largely ineffective. When it comes to home care, our nutritionist visits are not covered or reimbursed under Medicare. I think that is a real need.

Also, as a result of Gramm-Rudman, the nutrition program for the elderly in our county has been cut, so we do have people on a waiting list for the congregate meal site.

Mr. BONKER. Are you talking about title III of the nutrition?

Ms. POYNER. Title III, yes.

There are some areas in which we have sort of compensated for that. We will put a care giver possibly in there but that is more

costly than it would be if they were to pay someone by the hour to do that. That is more costly than if they were allowed to go to the congregate meal sites or be allowed to get home delivered meals.

Another area of problem with nutrition and a real area is that people who need special diets cannot receive those special diets. For instance, in Washington County, the only place that they can receive special diets is if they live in Hagerstown itself, not in any rural areas. In Hancock where they get meals from the congregate site there they cannot get any special diets.

Another area for concern for home care is that of intravenous therapy. If a person is hospitalized and needs antibiotic therapy, for example, for osteomyelitis or a similar resistant infection it is covered in the hospital. If they go home, where very frequently they could be cared for adequately, that drug itself is not reimbursed by Medicare.

There are two printed materials that I also did not mention in my written report, and I think your committee has a copy of them. They are materials from the National Association of Home Care. One of them is the "Attempted Dismantling of the Medicare Home Health Care Benefit," and the other one is "Toward a Nutritional Home Care Policy." I believe that probably all of your committee has that. I think, "Toward a Nutritional Home Care Policy," was made available to each one of the members on your committee, if I am not mistaken. That really expresses a lot of our feelings about Medicare home health care benefits in Washington County.

I think that the big need that we have is perhaps a consideration of being less restrictive on the part of our intermediary for, what is home bound, and what is skilled needs. This would allow us to give some lesser level of care to the more skilled needs.

[The prepared statements of Mrs. Poyner and Dr. Brace follow:]

PREPARED STATEMENT OF BETTY J. POYNER, R.N., HOME HEALTH SUPERVISOR, DIVISION OF NURSING, WASHINGTON COUNTY HEALTH DEPARTMENT

Washington County has a population of 110,530. 20,839 of this population is elderly (above age 60). There are 18,085 Medicare beneficiaries and 11,085 of these are retired. In addition to this 11,085 there are widows who are elderly, but are not classified as retired. The Commission on Aging for our county lists 5,000 elderly as low income.

Since 1/5 of our population is elderly, the Medicare and Medicaid programs are a real concern not only to our elderly but also to those of us who are providing services for them.

We understand, and agree with, the initiative on the part of the Federal Government to reduce the deficit. However, other stringent reductions were already in place including the DRG system and reduction in cost caps allowed for Home Health Agencies.

Across the board cuts due to Gram Rudman are having a detrimental effect on all Home Health Agencies. It is additionally affecting the government agencies who cannot claim all the business deductions that "for profit" agencies can claim. We are also affected bacause we are receiving an increasing number of patients with no reimbursement source.

It is difficult to understand the intent of legislature to attack the Home Health benefit of Medicare. The whole DRG process is placing more people with needs out of the skilled care facility and into their homes. Can the legislators not see that this will naturally increase the need for home care? Your own House Aging Committee has heard testimony from HCFA and from Congressman Martin Frost that patients are being prematurely discharged and needing increasing amounts of home care. (1)

Additionally, statistics prove that the percentage of elderly in our population is increasing as Americans live longer. Statistics also show that the elderly are more in need of home care because of their increased medical needs. In our agency approximately 72% of our patients are on Medicare, so anything that affects the Medicare program has a great impact on us.

One very difficult area for us is the application by our fiscal intermediary of the requirement for skilled. The judgement of that need is strictly subjective at the discretion of the reviewer. The denials state that the care was not "reasonable and necessary". Agencies in Maryland are experiencing denials for this reason when the intermediary have not even asked for additional information before they have denied the claim. Nurses on my staff will either discharge a patient before they really feel secure about their condition or they will make a visit at no charge in order to give the necessary support. It appears that our decisions are frequently based on what the fiscal intermediary will do rather than on what we professionally would determine is adequate care.

One area that is being attacked by our fiscal intermediary and one that is grossly inadequate in the Medicare system to begin with is the need for in-home aides to give personal care. Line #18 on the form #486 Medical Information form asks the question, "Is there an avail-

able, able or willing caregiver". If you answer that question with a qualitative yes, you will be denied payment for a home health aide. Frequently the caregiver may be willing, but unable to provide care because they work or are frail, elderly themselves.

Our agency has the case management for Maryland Medical Assistance Personal Care Program. We have 140 clients on that program and have seen how the care that a client receives is enough to enable them to stay in their own homes longer. We believe that if Medicare were more lenient in allowing aide service it would greatly reduce the expenditure for long-term care. The cost for that program is $10.00 per 2-3 hour visit and may be daily if necessary. If there were daily visits, the total bill for a month would be approximately $300.00 plus $40.00 to the agency for case management. Compared with nursing home charges of $1500.00 per month, it is a large savings. The aide visiting more frequently could help to prevent the need for more costly nurse visits.

There are many elderly people who are just above the income level for Medical Assistance, but cannot afford to pay a caregiver, who desparately need such a program.

Medicare will cover a home health aide to do personal care only while there is a need for skilled nursing or therapy.

Another area of need for reimbursement for home care is in the area of intravenous therapy. If a person is hospitalized, Medicare will pay for intravenous drugs. Antibiotic therapy is usually long-term for the treatment of osteomyelitis or a similar resistant infection. If the patient were allowed to receive the therapy at home, Medicare would pay for the nursing visit, but not for the usually very expensive drugs.

Cuts in Gram Rudman have also greatly impacted the nutrition program for the elderly in our county. Nutritional status in the elderly has such an impact on their physical state and frequently they do not eat well because they do not feel like fixing anything, they are unable to get to a store to purchase food or do not have the funds to buy it.

There is a need for reimbursement for nutrition counseling for home health patients. The skilled nutritional needs are many times as important as skilled nursing or therapies. Nutrition counselling is reimbursable in the hospital but because hospital stay is so short, there is not really time to do nutritional counselling when the person is hospitalized. The nutritionist in our health department either sees or reviews diet histories on approximately 1/3 of our patients.

Because of Gram Rudman, funds have been reduced to our Commission on Aging and there are people in elderly housing complexes that are on a waiting list to receive meals at the congregate meal sites. There are currently 10 people on a waiting list for the meals.

In addition to the problem of a waiting list at the congregate sites, it is impossible to service all elderly who really need subsidized home delivered meals. A problem that is especially evident in Washington County is the inability of the meal program to prepare special diets in areas outside of the city of Hagerstown.

When available a Gateway II worker may be assigned to help with meal preparation. The cost for that would be $7.40 for wages plus mileage which would be a total of approximately

$8.00. Commission on Aging subsidized meals cost $3.40. So if everyone who needed the meals could be served, it would be a savings of $4.60 per person.

We see the less skilled needs of the elderly to be a real area of need. They can be cared for at less initial expense and can prevent or delay admission to costlier long-term or acute care facilities.

As a closing remark, I would like to encourage you to support H.R. #4638. I believe it would improve Medicare Coverage and facilitate transfers from hospitals to home health agencies.

I would also like for you to oppose any future effort to eliminate the provision for waiver of liability for home health.

We appreciate your efforts on the House Select Committee on Aging and support you in your efforts toward fair, humane treatment for our elderly.

(1) National Association for Home Care Report #161

PREPARED STATEMENT OF KIRKLAND R. BRACE, D.D.S., HAGERSTOWN, MD

Currently 11.7% of the American population is 65 years of age or older. In the state of Maryland this population is expected to increase 63% by the year 2030. Except for children younger than age 6, individuals older than 65 have the lowest rate of utilization of dental services. In 1977 the average per capita health expenditure by older adults for dental care was only $32.00. Although 32% of this population utilized dental services in 1977, almost 50% of all elderly had not used dental services for 5 or more years. The rate of use was even lower for the edentulous elderly, 72% of the edentulous population in 1974 had not sought dental care for more than 5 years.

Considerable evidence exists to show that the incidence of coronal and cervical caries, periodontal disease, as well as benign and malignant tumors of the oral cavity increase with age, but there is no clear explanation as to why the elderly use dental services at a lower rate than medical services. Health care providers, planners, and advocates of Medicare reform have all identified cost as being a primary barrier preventing older persons from seeking dental care. It is important to point out that Medicare will pay medical expenses from 50-80% but does not pay for dental services. In the over 65 age group, one predisposing condition which decreases utilization of dental care is lack of education. Enabling variabilities are the second set of conditions associated with the lack of dental care utilization. These include lack of family income, dental insurance, and community resources (urban patients more easily accessible to dentists due to easier accessibility).

Residents of nursing homes present among the country's most neglected citizens. Currently 20% of all Americans over the age of 65 will spend a portion of their lives in a nursing home. This population is the fastest growing segment of the health care population with an estimate

three million Americans by the year 2030. An American Dental Association study of Vermont nursing home residents found 83% in need of dental care.

Long-term care patients, perhaps more than any other population, need special, daily attention to their oral health. The oral health problems of the elderly and chronically ill or disabled in nursing homes are considered to be far more serious than oral health problems among the rest of the population, including the elderly outside nursing facilities. Why has the oral health of more than a million persons in long-term care facilites been inadequate? There are many reasons but two major reasons are lack of in-house or portable dental equipment in these facilities and lack of adequate funds. The Medicare or Medicaid programs, for which nearly all long-term care patients are eligible are significantly deficient in dental benefits.

Presently, Medicare coverage extends only to a few, very limited oral surgery benefits. Medicaid coverage of dental services is also very limited for adults and coverage is different in every state. In the state of Maryland adults are eligible for dental treatment for acute, emergency situations only and the treatment covered is very limited. For patients confined to a nursing facility there are five restricted benefits allowed for dental treatment. These are emergency services, rebasing or repairing of dentures, maxillofacial prosthesis associated with traumatic injuries, non-emergency periodontal therapy to prevent problems associated with phenytoin sodium drug medications and drugs dispensed by the dentist within the limitations of the Medical Pharmacy Program. Unfortunately, this coverage under Medicaid is too limited and does not sufficiently cover this population. The limited coverage combined with the unrealistically low fees which the Medicaid system pays for services rendered makes the little available support from outside sources inadequate.

For the elderly population, Medicaid in Maryland offers too little support for the population which needs the most dental care. But at least the State of Maryland offers some coverage under Medicaid, whereas 19 states and territories in the United States do not offer any dental benefits for adults at all. The Medicaid system along with the Medicare system need to be revised to better provide dental services for the elderly. These systems also need to address the extreme lack of funds and equipment to the long term confined patients in hospitals, intermediate care facilities, skilled nursing facilities and private homes where patients are virtually neglected of any dental services. Besides funding and equipment to treat these patients in these facilities, administrators and supporting staff need to be educated as to these deficiencies in oral health care provided to these residents so that all groups can work together to better provide the much needed dental services to the elderly.

Mr. BONKER. Thank you very much, Mrs. Poyner.

We now move to Horace Murphy, who is the president of the Washington County Hospital Association.

STATEMENT OF HORACE W. MURPHY

Mr. MURPHY. Thank you, Chairman Bonker, Representative Byron. It is indeed a pleasure to be asked to participate in this hearing.

In the interest of not being repetitive and wasting the time of those in the audience and yourselves as the investigative staff, I have a couple of brief remarks that I would like to make relative to some things that were said earlier by a representative from HCFA, and that is pertaining to HMO's and the rural setting.

First of all for an HMO to be successful it requires a stable economic environment and as you are well aware, most rural environments are not necessarily stable. It requires a younger population, and you have already heard testimony to the fact that our populations are aging faster than the national average. It requires a large population base in order to actuarily be successful.

The one component that isn't discussed very frequently is essential that a group of younger doctors are willing to work under contractual arrangements in place of fee-for-service physicians. The fee-for-services physicians are the mainstay of the primary care givers of medicine in our communities.

So, as grandiose as this idea is, the HMO's work well in the metropolitan areas. In rural Maryland, it is going to be very difficult to get them to develop because the conditions which make them grow are not here.

The bulk of our testimony has been submitted to you and has been prepared in conjunction with Mrs. Anne Mayhew, who is our utilization review quality assurance coordinator for the hospital. I thought it would be much more meaningful for you to hear directly from her because she is the person who every day reviews the cases that are in our hospital and that are denied. She can give you some concrete examples of the kinds of problems we face every day in finding reimbursement for care that is being denied. Looking at the humanitarian aspects of patient care, I believe that the bureaucratic solutions being provided through Medicare are not currently meeting the needs of the rural elderly.

[The prepared statement of the Washington County Hospital Association follows:]

PREPARED STATEMENT OF THE WASHINGTON COUNTY HOSPITAL ASSOCIATION

Mr. Chairman, I am Anne D. Mayhew, R.N., Director of Quality Assurance and Utilization Review at Washington County Hospital Association, and on behalf of Washington County Hospital Association and our health care consumers in Washington County, I am pleased to have this opportunity to present our testimony befor the Subcommittee on Housing and Consumer Interests of the House Select Committee on Aging. The Health Care Industry and the Washington County Hospital Association support incentives in the Medicare Program which promote efficient delivery systems and cost effectiveness. However, by creating incentives to improve efficiency, the hospitals as well as hospital managers are at risk for any factors affecting costs, including those beyond control of the manager. Because of the uncertainties of the federal budget process, hospital managers are compelled to budget with little advance knowledge of prices that will be paid for their services or the policies under which they will operate.

UTILIZATION REVIEW MANAGEMENT SYSTEM

In 1984, Washington County Hospital Association implemented a very comprehensive Utilization Management System in an effort to improve efficiency while maintaining a high level of quality care.
The Utilization Review System implemented 7 objectives. The first six months of our implementation accomplished the following:

1. 10% of all potential admissions were safely diverted to a less costly setting. Those settings including the Ambulatory Services Unit, Ambulatory Surgery Unit, and Home Health Care Services.
2. An additional 10% of scheduled elective admissions were diverted to our Pre-admission Testing Program. This shift eliminated an average of 40 unnecessary pre-operative days per month.
3. Patient days denied for non-acute services decreased from 6% of our total patient days to 2% of our total patient days.
4. Extensive physician education resulted in positive changes in their practive patterns which enabled the hospital to improve efficiency and maintain the quality of services rendered to our patients.

In October of 1985 the Department of Health and Mental Hygiene implemented House Bill 1071. This bill required all Maryland hospitals to implement utilization review standards. There were 8 standards in the bill, and Washington County Hospital had already identified and had fully implemented

7 of those standards eighteen months earlier. At the present time Washington County Hospital as well as other hospitals are dealing with over 40 external review agencies performing the same review process. These review agencies are duplicating the same efforts we have been accomplishing for almost two years. The administrative costs incurred by these agencies only adds to the cost of health care unnecessarily.

MEDICARE POPULATION AT WASHINGTON COUNTY HOSPITAL

In 1980 the U.S. Census Bureau estimated that in 1985 the population in Washington County of residents 65 years and older will be 12.9% of the total population. In FY 84-85 Washington County Hospital treated as inpatients approximately 60% of the Washington County Medicare population. The Medicare population at Washington County Hospital represents 30% of our total patient population, 46% of our total patient days, and 45% of our total generated charges. The average length of stay for our Medicare population is at present 9.2 days. This is an 8% decrease in length of stay from the previous year, and is largely due to the hospitals efforts to reduce unnecessary and inappropriate services and to deliver necessary services more efficiently.

THE EFFECT OF THE PRO

The PRO was implemented in the state of Maryland in October of 1984. At that time all hospitals were under a favorable waiver status. That waiver meant that if hospitals were able to maintain a denial rate of 2% or less those days denied would be reimbursed by the Medicare program. In March of 1986 the favorable waiver status was withdrawn from all Maryland hospitals. This means quite simply that each denied admission will result in actual monies lost. The cushion is no longer there which enabled those marginal patients to be treated. This move has essentially eliminated the hospitals' committment in recognizing and responding to severe social and economic conditions that may sometimes require a non-acute but supervised enviornment for our elderly rural health care consumers.

This move by the PRO is taken quite personally. Those hospitals like Washington County Hospital whose early interventions and actions have demonstrated improved efficiency will no longer be rewarded for their voluntary efforts.

CASE PRESENTATION # 1

An 80 year old female was admitted to our hospital in December of 1985 with documentation to justify an impending stroke. This woman was found wandering from her home, inappropriately dressed

for winter, confused and she was " afraid of freezing to death". This woman was not in compliance with her high blood pressure medicine and was at great risk for a major stroke. The patient's husband had died on week previously and there was no one taking care of her. This patient remained in the hospital for 4 days and then transferred to an appropriate nursing home setting. The PRO denied the entire admission. Had the stroke not been averted, Medicare would have paid on the average $4,096.00 to treat this patient for 11 days. This patient's bill was only $1,173.00.

This case makes me wonder whether the Medicare Program and the Health Care Industry is abandoning the methodology of preventive medicine?

CASE PRESENTATION # 2

An 80 year old male was recently hospitalized for a hernia repair. This patient had severe Parkinson's disease. The one night stay was approved by the PRO, and the patient's recovery was uneventful. The day of discharge the patient's wife had fallen at home, fractured her hip, and required sugery that day. Since this patient could not care for himself and no family was readily available the patient remained in the hospital 2 additional days until family arrangements could be made. The PRO denied those days.

We realize these days are non-acute, but it appears that we are losing social conscience and there appears to be no consideration for human needs. The inhumanity of the system impairs our ability to assure quality and/or provide basic sustaining needs for a post-acute admission under these multiple calamity conditions. In the community that Washington County Hospital serves there is a larger and larger percentage of our population with no immediate support systems readily available. The hospital must continue to respond to these people.

The selection of cases for retropective review by the PRO is based on problem areas, ie: problem DRG's, problem ICD-9 codes, problem procedures. It is reasonable to assume that the more focused the review is, the greater the rejection rate will be. If carried to the extreme it is conceivable that hospitals could be looking at a 100% denial rate and at risk for unjustifiable sanctions. As each PRO contract renewal period appears the concentration of review will shift depending on the previous year's data. The next step we forsee is that Medicare will begin denying those days that patients are waiting for extended care bed availability. Those days are beyond the control of the

hospital, the physician, and the patient. Therefore they are at the mercy of the federal reimbursement system to allocate resources for social days when there are no available alternatives.

At Washington County Hospital the most recent 6 months statistics identified 1,445 days as "days waiting placement". This would mean in one fiscal year a potential loss of over $650,000.000 if these days are denied. Washington County Hospital Association would perceive this as a social and moral abandonment of these patients and would greatly compromise our financial viability. As the only health care provider in Washington County we are morally obligated to care for these patients until an appropriate setting is available, and although this would put the hospital at some financial risk we can not and we will not turn our back on this moral obligation.

HOME HEALTH CARE FOR THE POST ACUTE PATIENT

At the present time Medicare does not reimburse for nutritional counseling. Nutritional inadequacy is identified as a significant contributing cause for complications of many disease entitites, including Diabetes, Cardiac, and Circulatory disorders. Adequate education and counseling is being denied to these post hospitalized Medicare patients. Non compliance of post hospitalized diet instructions is the biggest reason for readmission of many of these patients. The most current statistics for Washington County Hospital patients identified that 42% of our patients require modified diets for disease control. Since the length of stay is only 9.2 days, there is little time for comprehensive nutritional counseling as an inpatient. Followup outpatient counseling and monitoring is necessary to assure patient compliance and to avoid or prevent rehospitalization of these patients.

At the present time Medicare does not reimburse for home IV drug therapy. Medicare will pay for the skilled nursing visit, but not the drug itself. Without that reimbursement Medicare are compelled to remain in the acute setting when indeed their continued treatment could be safely accomplished with the Home Health Care team.

CASE PRESENTATION # 3

A 70 year old male was recently hospitalzed for osteomyelitis and required a six week therapy of IV antibiotics. Because of the lack of reimbursement of the drug in the home setting the patient remained in the hospital for the full treatment. This patient was medically stable for discharge after the first 2 weeks of treatment. Medicare paid the full six weeks of stay at a cost of over $10,000. Had this

patient been discharged with Home Health Care services the entire cost saving would have been approximately $5,000.00, including the 2 week hospital stay.

This case clearly speaks to the need to maintain and enhance reimbursement of Home Health Care services as a reasonable cost saving alternative to acute hospital care.

Effective October 1, 1985, Medicare coverage of home oxygen was considered necessary only for patients with severe hypoxemia. In order to determine the significant hypoxemia the supplier must provide results of a blood gas analysis initially, and whenever the patient has undergone a major change relevant to his use of the home oxygen. The physician must supply a statement indicating that other forms of treatment have been tried, but have not been sucessful. Patients on home oxygen prior to October 1, 1986 have one year from their inital setup date to meet the justification guidelines for reimbursement. Failure to justify this need puts the supplier in a position where he might continue servicing the patient without assurance of payment, or without the fair opportunity to discontinue the home oxygen system if his claim was to be rejected.

On October 21, 1985, the allowable reimbursement for seat lift chairs was set at $850.00, a decrease of $545.00. from the previous allowable charge. This has forced the manufacturer's to make a seat lift chair of lesser quality in order for suppliers to continue providing this equipment service. As a result of this change, all claims for seat lift chairs fall to a medical review committee, who know little of the actual needs of the patient. As a result very few payments are being made to the suppliers. This penny wise and pound foolish methodology puts the supplier in a position of eliminating this product line, thus making it very difficult for a patient to obtain a medically necessary piece of equipment.

THE EFFECT OF GRAMM-RUDMAN-HOLLINGS ACT

The passage of the Gramm-Rudman-Hollings Act caused a cut in the Medicare reimbursement of 1% effective March 1, 1986, with potential cuts of 2% on October 1, 1986, and additional 2% cuts for each fiscal year 1987 through 1991. Until the issue of the constitutionality of this legislation has been resolved and legislation gets through with the budget process we are forced to assume the worst case senario. If this cost cutting mentality directed toward the Medicare program contiues it will be looked upon by providers as economic euthanasia.

READMISSIONS OF THE MEDICARE PATIENT

The quality assurance function at Washington County Hospital concurrently reviews every patient who is readmitted to our hospital within 30 days of a previous dischage. Washington County Hospital is deeply concerned over the documented increase of geriatric readmissions. In 1984 an average of 14 patients per month were readmitted within 30 days of a previous discharge. At the present time we are experiencing an average of 22 patients per month. Sixty-one percent of these readmissions are Medicare patients with an average age of 72.7 years of age. The average days of these patients between discharge and readmission is only 8.6 days. The overt pressure placed on doctors and hospitals to discharge patients in order to stay within the DRG has been the direct cause for many of these readmissions. Washington County Hospital has worked diligently to reduce unnecessary health care expenditures, but at what cost!!! At Washington County Hospital the "fat" has been trimmed yet the pressure remains. If 10% of the GNP is too much to pay for the highest quality health care system in the world, and at that expenditure rate we must continue to increase co-payments and reduce services for our aging, infirmed, disabled and mentally imcompetent and now it appears that the only options left are to drive them from their homes, and into the streets, to deinstitutionalize them or let them die of neglect. Then I would say it is time to repriortize our social committment.

CONCLUSION

The federal government has not yet resolved who is responsible for our ill aging population. In essence the federal government has shucked its responsibility in this regard, and now state governments are confronted with the same dilemma, largely due to decreased federal support of programs requiring matching funds. The decision we now face is local responsibility versus national responsibility. In 1966, health care was declared a very high priority - a right of every citizen, but know it seems that the federal government considers it not affordable. If this is not the case, where is our priority for those who have given us our heritage? Must we conclude that it lies in larger expenditures in foreign aid and in the arms race? And is this the legacy we chose to leave to our children?

The decade of the 1980's is not yet history. We have an opportunity to reassess our committment to a generation of people who have provided us with the increased standard of living and affluency in the history of mankind. Would it not be a sad commentary when the history is written that we failed to keep our committments to those who have provided us such a rich legacy?

The extravagance of the 1970's was in fact extravagance. That extravagance

resulted in tremendous strides in health care technology, drug technology, more and better educated physicians, better health care facilities, and access to health care for all persons. We realize our extravagance must be brought back to reality. We have demonstrated that health care services can be provided in a more reasonable fashion and with less cost. The government needs to understand the point of return when the pendulum swings the other way. The government needs to know and recognize that a system is not driven by economics alone, no matter what the government does it will be nearly impossible with the rapidly increasing aging and sick population to spend less than 10% of the GNP on health care.

We need to continue to measure and reassess priorities so while we try to take extravagance out of our expectations we don't take the quality out of that care. The health care industry is willing to cooperate, to be creative, to be innovative, and to be prudent in the management of its resources as long as resources do not get restricted to unsafe levels. We are rapidly at the point of diminshed return through the federal system for ratching down costs. We need to turn our attention to the creative and innovative alternatives of caring for our elderly. Alternative to acute hospitalization made available to the elderly would maintain their dignity and their independence. The health care delivery system in this country has been second to no other in the history of mankind. As a society we can ill afford to substitute our cultural and social priorities as we have seen occur in the extravagance of our defense budget.

Mr. BONKER. Mrs. Mayhew.

STATEMENT OF ANNE D. MAYHEW R.N., CPQA

Mrs. MAYHEW. Mr. Chairman, Representative Byron, we are pleased to be here. We do feel we have some significant points to make to this committee and to the people in western Maryland.

In 1984, the Washington County Hospital Association had implemented its own very comprehensive utilization management system. We saw the need was there. We saw what was coming ahead in the next couple of years with the peer review organizations and we felt an obligation to deliver our services more efficiently and to reduce unnecessary and inappropriate services for our patients.

We went ahead with that thought and implemented a very comprehensive program. It had seven objectives. During the first 6 months of our utilization management program, we were able to reduce by 10 percent the number of potential admissions to the hospitals.

We were able to divert them to alternate care settings, less costly settings, ambulatory surgery units, ambulatory services units, home health care. We also were able to take an additional 10 percent of our potential admissions and eliminate the preoperative day.

We have a very comprehensive preadmission testing program which allows the patient to come in several days before surgery, have all the required preoperative lab and x-ray studies done, and come into the hospital the morning of surgery. This, on a monthly basis, eliminated 40 per month unnecessary preoperative days.

Patients denied for nonacute services at that time was ranging to about 6 percent of our patient population. In the first 6 months of our program, that denial rate was reduced to 2 percent of our total patient population.

We were able in that timeframe to provide extensive physician education, extensive community education. We did radio shows. We did TV programs. We did news articles, to let the community know that Washington County Hospital was committed to the incentives to reduce unnecessary care and to deliver necessary care more efficiently.

In October of 1985, a time when the Department of Health and Mental Hygiene recognized the need for comprehensive utilization management, they implemented House bill 1071. That bill had eight objectives that required minimum utilization review standards. We had already identified and implemented seven of those standards almost 18 months earlier, were very successful, and had a very easy time in implementing the last objective.

What we are dealing with at the present time, which I think you need to know, is that we have over 40 external utilization review agencies operating throughout the country. They are interrupting our daily work flow. The nurses that are doing concurrent review on the floors are getting continuous phone calls from outside review agencies regarding the appropriateness of the stay of a patient.

Mr. BONKER. You are leaving the impression that 40 review organizations are in some way involved in your institution.

Mrs. MAYHEW. No; these are external review agencies that are contracted to different insurance carriers.

Mr. BONKER. So you are talking about private carriers.

Mrs. MAYHEW. These are private third-party carriers.

Mr. BONKER. You have your own agencies and you have to deal with all of them?

Mrs. MAYHEW. Yes, we do; on a daily basis.

Mr. BONKER. So Medicare is just one of many?

Mrs. MAYHEW. Yes, it is. If the external review agencies would realize that in the State of Maryland that House bill 1071 requires us to do what they are trying to do on a daily basis and also on a retrospective basis. The Medicare peer review is only a retrospective review. We are doing 100 percent concurrent review in our hospital. Every patient's record is looked at on a daily basis.

Mr. BONKER. When you say you are doing a review, who is doing the review?

Mrs. MAYHEW. The Washington County Hospital staff employees are doing the concurrent review.

Mr. BONKER. So it is an inhouse review?

Mrs. MAYHEW. It is an inhouse review.

Mr. BONKER. I am impressed with how you are approaching this task, but for the outsider that doesn't necessarily provide any comfort if the review results in unnecessary stays in the hospital at additional cost to Medicare. I mean, you need to have some kind of an outside check so you just don't pad your own bed.

Mrs. MAYHEW. Right, and the peer review is one of those outside checks.

What I would like to say are a couple of cases that we have seen denied by the PRO that we find totally unjustified.

Mr. BONKER. So you have had a PRO denial?

Mrs. MAYHEW. We have had many PRO denials.

Mr. MURPHY. Excuse me. I think that to directly address that question, Anne, you and I were talking about this on the way here; we have had——

Mrs. MAYHEW. Fifty-one cases.

Mr. MURPHY. Fifty-one cases denied in the last fiscal year.

Mr. BONKER. This is a PRO recommendation for denial of payment?

Mr. MURPHY. Yes.

Mr. BONKER. Is this PRO out of Baltimore?

Mr. MURPHY. Yes, the same one that my colleague from Garrett County mentioned.

Mr. BONKER. Either they are very excessive or you are very sloppy; something is wrong here if you had 50 recommendations for denial.

Mr. MURPHY. Well, I think our whole point, Mr. Chairman, is that our program has tried to be extremely PRO active in this regard and prevent our being denied payment. Hospitals cannot manage and stay viable as health care providers to our communities if we don't take a defensive approach and make sure that we minimize the number of denials that we get. And for that reason, I

have a staff of seven people headed by this good lady here who does exactly that.

Mr. BONKER. This is rather extraordinary. I was concerned that there would never be a denial and you are telling me there are 50 some denials on your hospital alone.

Mr. MURPHY. That is correct.

Mrs. MAYHEW. Yes, there is. We have exercised the appeal process in approximately one-half of those denials in 25 cases. We have heard back from the PRO organization that at this point we have had eight responses. They have rescinded their original decision in over 80 percent of those cases.

Mr. BONKER. I didn't get the impression from the Garrett Hospital administrator, at least from the medical director, that they had problems of denials. He said that they were excessive, that they were rigid, I guess.

Ms. BURNETT. I do the utilization for our hospital and we had 17 denials in one quarter.

Mr. BONKER. You had 17 denials and you have had 51 in one quarter. Does that mean that payment is not forthcoming?

Mrs. MAYHEW. That is correct.

Mr. BONKER. And who absorbs the loss?

Mrs. MAYHEW. The hospital.

Mr. MURPHY. Let me back into this with you, if I may. The loss, first of all, is absorbed by the hospital. But there is a lot of psychological loss that backs up from that to our senior citizens because when we get denied, the physician gets denied, then the senior citizens are told that the claim is denied. They go through the anxiety of wondering how the claim is going to get paid for because I do not believe, despite testimony otherwise, that the communications systems tell our aged population that they do not have to pay. It is the responsibility of the provider, to be as adequate as we would be led to believe.

And they go through this whole period of anxiety wondering whether or not the hospital is going to send them a bill or whether their insurance company is going to send them a bill. It is months and months later after the hospital has initiated all of the actions to appeal the decision of the PRO, that perhaps the bill will get paid and perhaps it won't.

Mr. BONKER. I can appreciate the anxiety, but my concern is, why the denials in the first place? Can you give me a common example why this review authority is denying a payment, if it must be based on prematurely releasing patients or some lack of quality care.

Mrs. MAYHEW. No, these denials are all based on what the peer review organization considers inappropriate admissions to the hospital.

Mr. BONKER. Inappropriate admissions?

Mrs. MAYHEW. To the hospital. These patients do not meet the cookbook guidelines of intensity of service and severity of illness. If a patient's blood pressure is not a certain amount, regardless of whether the patient is showing up with symptoms of an impending stroke, if the blood pressure is not a certain level, that patient is not considered an acute patient for hospitalization.

Mr. BONKER. So we are talking about most of these denials involving admissions?

Mrs. MAYHEW. Yes.

Mr. BONKER. They are saying you are admitting people who might not otherwise be covered under Medicare, right?

Mrs. MAYHEW. Yes.

Mr. BONKER. Now, if that person has supplemental insurance, does that mean that that insurance does not cover it if Medicare does not?

Mrs. MAYHEW. If Medicare has denied it then the other insurance carriers will and, the copayments will not be made.

Mr. BONKER. Well, as a business, is it wise to continually accept patients that are not going to be properly covered by Medicare?

Mrs. MAYHEW. Mr. Chairman, let me give you this example of a patient. We had an 80-year-old female that was admitted to our hospital in December 1985, with documentation to justify an impending stroke. This woman was found wondering from her home. She was inappropriately dressed for winter in the streets, confused, and she was "afraid of freezing to death." She was brought to our emergency room. She was not in compliance with her high-blood-pressure medicine and was, indeed, at great risk for a stroke.

The patient's husband had died 1 week previous to this admission and there was no one taking care of her. The patient remained in our hospital for 4 days and then transferred to an appropriate nursing home setting. The PRO denied the entire admission.

Had the stroke not be averted, Medicare would have paid on the average over $4,000 to treat this lady for 11 days. This lady's bill was a little over $1,000. We did not receive payment for those 4 days.

The reviews by the peer review organization, Mr. Chairman, are retrospective. They look at the outcome of the hospitalization. If the outcome did not progress to what the presenting physicians assumed with his assessment and his expertise, and if the patient did not get acutely ill, and seriously ill, in retrospect, that entire admission is denied.

Mr. BONKER. It seems to me a patient would have to be referred to the hospital or admitted upon recommendation of a physician. In the case that you just cited, the person more or less wandered into the hospital.

Mrs. MAYHEW. She was brought to the emergency room, was seen by the emergency room staff and admission was recommended by the attending physician.

Mr. BONKER. The attending physician did recommend?

Mrs. MAYHEW. Yes.

Mr. BONKER. And denial was still forthcoming on that basis?

Mrs. MAYHEW. Yes.

Mr. BONKER. Well, that is a serious problem, and I can understand your perspective. On the other hand, one needs effective cost controls or we end up allowing a run on the trust fund and that means ultimately reduced benefits as well. So it is a tough one to deal with.

Mrs. MAYHEW. I believe, Mr. Chairman, at least at Washington County Hospital, and as a member of the Maryland State Association of Quality Assurance Professional, I am aware of many hospi-

tals that have very comprehensive in-house programs. When these denials come through, in the majority of cases they are surprises to us, even though we are out there on the floor every day reviewing every patients' chart and justifying each day. It surprises me, why are we seeing these surprises?

Mr. BONKER. Has anybody from the PRO come down and talked to you, because there was reference earlier from the—is that person still here, Ms. Koch—did she leave?

Ms. KOCH. I am still here.

Mr. BONKER. In a situation like this, you indicated in your earlier testimony that there would be some kind of instructional effort to talk to the hospital about what is, in this case admissible, and what is not admissible. It is difficult when Baltimore is far away and they are probably preoccupied with Baltimore. This is kind of a peripheral thing, but nonetheless, this is a serious situation.

Do you know if PRO out of Baltimore has made an effort to come down here and converse with hospital administrators and others to see what the problem is?

Mrs. MAYHEW. The nurse—pardon me.

Mr. BONKER. I was more or less directing the question here, but I would love to hear from you as well.

Ms. KOCH. I can't speak specifically today as to what the activity of the Maryland PRO has been. I can speak to the activity of PRO's in terms of that education. The PRO does, in most cases, meet with hospitals from time to time. They do indeed talk with hospitals through the physician adviser as to why cases are being denied.

Mr. BONKER. Mrs. Mayhew.

Mrs. MAYHEW. The peer review organization nurse that comes in and does the retrospective review——

Mr. BONKER. A nurse from where?

Mrs. MAYHEW. From the peer review organization.

Mr. BONKER. Comes down from Baltimore?

Mrs. MAYHEW. Yes.

Mr. BONKER. A nurse, not a doctor?

Mrs. MAYHEW. A nurse.

Mr. BONKER. OK.

Mrs. MAYHEW. She sends ahead of time a list of the records requested for review. The record review is done in my office. However, there is little communication with this nurse as to what her findings are until several months down the road when we get a final determination.

There is a physician advisor for the peer review for this area. That physician advisor is one of our own hospital pediatricians.

Mr. BONKER. And he disagrees with the nurse, I imagine, in most of these cases?

Mrs. MAYHEW. No; in most of the cases, he concurs with the findings of the nurse as far as nonacute admissions to the hospital.

Mr. BONKER. Well, then, you have got to ask yourselves whether you are admitting people under the pretense of Medicare that you shouldn't be admitting.

Mrs. MAYHEW. I think it is important to realize, too, that the cases that we have appealed to the PRO, we appealed on the basis of the inappropriate application of the criteria by the physician advisor. They have rescinded those denials.

Mr. BONKER. But this is a matter where you have a nurse supposedly trained in this area who comes down and confers with you and the attending physician?

Mrs. MAYHEW. No; she does not confer with me. She does the review logistically in my office.

Mr. BONKER. Oh, I am sorry. You said that she was in your office. Aren't you in the office, too?

Mrs. MAYHEW. I am required to provide a space for her to do the reviews.

Mr. BONKER. You don't meet with her?

Mrs. MAYHEW. No.

Mr. BONKER. Who does she meet with?

Mrs. MAYHEW. The physician advisor.

Mr. BONKER. The physician advisor, and in most instances he has been backing her up?

Mrs. MAYHEW. Yes.

Mr. BONKER. Interesting.

Mrs. BYRON. Is it usual that a pediatrician would be reviewing a senior citizen's paperwork?

Mr. MURPHY. Let me take Anne off the hook, if I might. I think I am here to take the flack on the front line.

Mrs. BYRON. Before you say anything, it just seems to me if you are having a review, it should be somebody that should have an expertise in the area of the case you are reviewing. The pediatrician is the PRO individual in the area. It seems to me that when you are dealing in the area that we are dealing in, you should have someone who has expertise in that area.

Mr. MURPHY. May I ask a rhetorical question, and please, I beg that it not be interpreted as being impudent. I really think the problem in this situation is, who wants the damn job.

Mrs. BYRON. Well, that was the question I posed to one of the other panelists when I asked, is this a job that is designated by the local medical society? Does someone say it is your time to serve on this review, as opposed to somebody that is appointed by the State, or does it come on a county basis?

Mr. MURPHY. Mrs. Bryon, I submit it goes to the lowest bidder.

Mr. BONKER. No; I think Mrs. Bryon has come back with an appropriate rhetorical statement. I mean, we are talking about citizen responsibility. Doctors are citizens too. If they want to keep the Feds out, and if they want to avoid a situation where we are going to have Washington, DC bureaucrats come down here and conduct this review, then we want to see volunteer citizen involvement. If you can't do it, if nobody wants to do it, and if doctors just want to pursue their economic interests and not participate in an honest way in this process, then the only answer is to have Federal or State bureaucrats come down and do it for them. So it is not a pleasant job.

You know, there are some unpleasant jobs that we have to do in our work in the Congress. It is like what I said about the reluctant son getting up out of bed, and facing some of these responsibilities. I am glad that he is there doing it, though I question, with Mrs. Bryon, whether a pediatrician ought to be the person. If you want to keep the Feds directly out of this, then self-policing and local in-

volvement is the best way to do it. If nobody wants to do it, then the only choice is for the Feds to come in and do it.

Mr. MURPHY. Mr. Chairman, I concur with that fully. I think the problem is the message hasn't gotten across yet, and it will.

Mr. BONKER. I don't know where we are in this hearing.

Sir, I usually don't do this, but you look like you have something important to say. Could you identify yourself for the record?

Dr. MANCE. My name is Dr. Andrew Mance. I have a practice in Oakland, MD. The young lady from Garrett County stated she had 17 rejections in the past quarter. I happen to be the man who had about half of those rejections. The patients were 81 years and above. One patient of those seven or eight that I had, came to me in December and was very seriously ill. I barely got her through to where she was finally sent to a nursing home. She was bleeding and had to have a D&C. It was not prearranged.

Now, the other patients were not disqualified because of not necessarily being admitted to the hospital, but because they were kept too long for the simple reason that—also in January with the review process breathing down my back—I got the feeling I should try to help this patient. I thought I had her in reasonably good shape, but this time around, within 7 days she was back.

Now, I am going to treat a patient who needs to be treated. A patient of mine got a bill for $5,000 for medical care which the utilization review does not regard as being necessary. Also, I got a letter from some organization that says I am responsible for that bill. There is extreme pressure on us.

I have here 15 or 20 little slips of paper that I can demonstrate to you, each saying, did the patient show reasonable or acute criteria? Show reasons for criteria. Then they have, could this examination have been done on an outpatient basis. But the patient is already in the hospital, is not able to go home, come back again and get it done on an outpatient basis.

Somewhere along the line, the physicians are not thinking, the nurses are not thinking, the hospital administrators are not thinking. I am fighting a battle all alone and I get hell for it.

Mr. BONKER. You mentioned earlier that there were 40 review organizations involved through the various carriers. What is your track record when it comes to private review?

Mrs. MAYHEW. We have had, to this date, one denial from a private review and it was appealed. The denial was rescinded.

Mr. BONKER. So you are saying that the public review process is far more rigid and denials are more common than you find in the private review?

Mrs. MAYHEW. Yes.

Mr. BONKER. I really don't know how you deal with a problem like this. I think it is terribly important to the committee's record that we have this testimony, and that Mrs. Bryon and I have a chance to more fully understand what is involved. I am not sure that our intent in Congress was that a nurse be the one to come down and make some of these judgments, but that is, of course, why you have a local physician involved as well.

I would be interested to hear from the Sacred Heart Hospital, who is coming up next to testify, to see what their experience has been. I'd also like to get a better sense of whether the problem

your hospital is having is unique to the system or whether it is something more commonly experienced with other hospitals and other physicians, as well.

One more comment, and then we will get to the next panel.

Ms. BURNETT. A lot of the problem is that a person 65 or older is judged by the same criteria as a person who is 95. A lot of the problem, is the criteria that we are forced to use. There is no allowance for social problems and these folks have social problems.

Mr. BONKER. Thank you.

Mrs. BYRON. We are operating under time constraint, yet we have gotten into an issue which to me is very critical. I think you are so accurate in looking at the case history of a 90-year-old versus the case history of a 68-year-old, although sometimes a 65- to 68-year-old can have the same type of case history as a 90-year-old. I think you have to look at the overall encompassing history and the economic situation in many cases.

Mrs. POYNER. Could I make an additional comment? In regard to home health, I know there has been some impetus in the thinking in Congress on prospective payment for home health. Given all the problems that prospective payment has demonstrated in the hospital situation, it is really important to us in home health that if possible your committee recommend that prospective payment for home health not be instituted. The cost per visit or the payment per visit is by far better payment than prospective payment because home health is the end. When they are out of the institution, they are home. This really is the end of their services, so it really is important to us that prospective payments not be instituted.

Mr. BONKER. Mrs. Poyner, what is your per visit reimbursement now?

Mrs. POYNER. Our skilled nursing visit is $50. That is a little bit less I think than the national average. I think that is $53.

Mr. BONKER. So you are saying to visit a home to provide some medication or whatever is about $50 per visit?

Mrs. POYNER. Right.

Mr. BONKER. What is the nursing home per day reimbursement?

Mrs. POYNER. OK. Average about $62 a day in a nursing home. A nurse's visit in a home health situation may not be daily and usually is not. Whereas in a nursing home it is going to be daily, so the costs are going to be more.

Mr. BONKER. So reimbursement under Medicare is approximately $61 a day?

Mrs. POYNER. Right.

Mr. BONKER. You know, the whole idea behind Medicare is not only a matter of setting up a program to help cushion the expense of health care but to try to make the whole system more efficient. We would have in the first instance inpatient hospital treatment; then what was called an extended care facility, which was a nursing home; and then as soon as patients were able, they would be moved into their home and receive home health care.

That would be a lot less expensive and a lot more efficient. We ought to be careful about how we open up the program. I mean, you would like to see eligibility in ways other than hospital, nursing home, home health. The nursing homes would like to see pa-

tients come directly in to the facility, rather than going to hospitals first. But you have got to appreciate the cost impact.

We in Congress are trying to keep the Social Security Trust Funds solvent. We can't increase taxes any more and we don't want to reduce benefits. If you open the gate and you broaden the coverage, then you are going to have less resources around to cover more acute illness.

Mrs. POYNER. Don't you think that was the thought behind the no longer required inpatient stay for home health? At one point, there was a required inpatient stay for home health. That is not true any more. I think that was the requirement behind it. I believe more people are going from the hospital directly to the home, which is eliminating the skilled nursing facilities.

Mr. BONKER. That is fine. It saves $12 a day.

Mrs. POYNER. Sure. Well, it saves more than that, because nursing visits are not usually daily. When we talk about costs, the home health aide is probably more frequent than the nurse. In our agency, a home health aid visit is $32.

Mr. BONKER. You sold me. I will go directly to the home health service.

Mrs. POYNER. Thank you.

Mr. BONKER. Mr. Garver, we have had a lot of medical people up here today with valuable testimony, but you are here representing senior citizens. What word do you have?

STATEMENT OF RALPH GARVER

Mr. GARVER. Mr. Chairman, thank you. I could pretty much echo some of the other comments, particularly those regarding Medicare. The people that we see and the clients that come through our Commission on Aging are basically lower income people. The deductibles in most cases are more than the seniors can afford to pay. They can't afford to buy the health insurance to cover the gaps in Medicare. The low income people, we feel, would be better served by some sort of blanket coverage from Medicare. The seniors just can't afford the deductibles.

They get confused over the paperwork involved. The claims service, as we see it and from what we hear, possibly needs to be improved. In some cases, not only the patient but those that work with Medicare are not totally clear on all of the aspects of the program.

The seniors worry about this type of situation all the time, and they really don't have much peace of mind. In some cases, they are afraid of it. They are sort of scared of the whole process.

I think there needs to be a more responsive need to the elderly as far as hospitalization is concerned.

We are concerned that Medicare could possibly help more in-home services, such as Alzheimer's care and meal preparation. I believe these were mentioned earlier. Medicare needs to cover age support services, other than skilled nursing care. These services would be supervised by a registered nurse. This way, those that need frequent care services for things even as simple as bathing, shaving, and medication monitoring, are able to receive them.

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We find in a lot of cases that the elderly won't even call or see a doctor, because they feel that they can't afford the cost. If something has to be given up, in a lot of cases, they would pay the rent or buy food in lieu of possibly seeking medical care.

Medicare does not cover dental areas, or such things as eyeglasses and hearing aids. Medicare does not cover in-home situations involving sheltered housing environments which Medicare could possibly be a part of on a long-term basis. These are the type of things that we see and hear from the seniors that come to our programs and from the services that the Commission on Aging in Washington County offers.

Mr. BONKER. Thank you, Mr. Garver.

Mrs. Byron, do you have any questions?

Mrs. BYRON. I have questions, but I am going to defer.

Mr. BONKER. We are already almost an hour over.

I want to thank you very much for providing us with valuable insights as to how this program is working, especially with respect to PRO's and denials on hospital reimbursement. Thank you very much.

The fourth panel, if you will come up and be seated at the witness table, Dr. Wayne Spiggle, Dr. Jane Fiscus, Sister Cecilia, and Mr. Donald McAneny. We are now moving to Allegany County, where we are located.

Mrs. BYRON. Once again, any of you that have the green slips of paper out there for comments, if you would please drop them off at the sign-in table and be sure to fill them out before you leave if you do have some comments to make.

All of you have been sitting here through the hearing, so again, if we could avoid redundancy and limit our remarks, it will give us more opportunity for exchanges. We appreciate very much your being here today and your patience in coming up to the witness table.

We shall proceed in the order in which I introduced the witnesses. Dr. Wayne Spiggle is with the Braddock Medical Group here in Cumberland, MD.

PANEL FOUR: CONSISTING OF WAYNE C. SPIGGLE, M.D., ALLEGANY COUNTY MEDICAL SOCIETY; JANE A. FISCUS, M.D., HEALTH OFFICER, ALLEGANY COUNTY; SISTER CECILIA, PRESIDENT, SACRED HEART HOSPITAL, DONALD C. McANENY, PRESIDENT, MEMORIAL HOSPITAL AND MEDICAL CENTER OF CUMBERLAND, INC., ACCOMPANIED BY MARY SUSAN STRAW, DIRECTOR, ALLEGANY COUNTY AREA AGENCY ON AGING, AND JOHN S. DAVIS, D.D.S., CUMBERLAND, MD

STATEMENT OF WAYNE C. SPIGGLE, M.D.

Dr. SPIGGLE. Thank you. I am just going to talk. I am not going to read the statement.

Mr. BONKER. The statement will be included in the record.

Dr. SPIGGLE. I think we are having a very important discussion on the PRO, and I think we ought to continue that. Relative to that discussions, I can only add these feelings and these perceptions.

First of all, I think a change in Congress, a mandate in Congress is needed.

Mr. BONKER. Not change in the membership, but in the policies?

Dr. SPIGGLE. No; we are appealing to you to make these changes.

The PRO is operating under certain strictures, as I understand it, which are a part of the present Medicare law and produce a basic fallacy. It is really wrong for the Federal Government, through this law, to expect every sick patient to fulfill a prearranged, and predesigned set of criteria in order to have a legitimate illness. This is basically what is happening.

The PRO is really asking the wrong question, "Is that hospital stay medically necessary?" They are also asking it in the wrong context. They are asking it from a technological context rather than a humanitarian context. The question should really be, and this has to come from Congress, "is there a safe alternative for that patient other than being in the hospital?" This is the care dilemma that we face over and over.

Some criticism, I think misplaced criticism, has been placed on physicians who will or will not participate as a local advisor of the PRO. I, in good conscious, cannot play that role until the right question can be asked. I appeal to either the nurse, who is very knowledgeable in looking after the PRO review, or the physician advisor. When I appeal to them that there are no safe alternatives to keeping this patient in the hospital or admitting him to the hospital, the answer is uniformly, "we agree with you, but we are bound by the criteria." The criteria have become the cook book, the Bible, we have to live by.

Actually, Medicare in this review process has effectively taken the physician out of the decisionmaking. The question isn't what are the patients needs and is hospitalization necessary to fulfill those needs, but rather; given those needs that require hospitalization, how do you get the patient to fit the Medicare criteria? That just isn't any way to conduct medicine in this country.

Mr. BONKER. Dr. Spiggle, we have had the Medicare Program for nearly 20 years. We have just recently set up this new prospective payment system. Let me ask you, is this a long-stem problem or is this the result of Congress attempting to force greater economies in the system through the DRG?

Dr. SPIGGLE. This is a new problem.

Mr. BONKER. This is a recent problem?

Dr. SPIGGLE. The problem is not necessarily that we have to do things differently. We do need to do things differently and more cost effectively. This is being done. The problem is, there is no check and balance. There is no, as you have said, flexibility in the present system. We need to make some changes so that there is flexibility. What we are appealing to you for is a fairly simplistic idea.

When there is a care dilemma and the patient doesn't fulfill these criteria, but the only safe alternative for that patient is to be admitted or to be kept in the hospital, then there should be an avenue for the patient's physician to appeal to the physician reviewer or anyone else who is responsible to the hospital. If there is concurrence, then I think the patient has the right to have those criteria set aside in favor of good medical care.

Mrs. BYRON. Let me ask you a question, because in your testimony for the record, you have cited five various cases. Let me go into one about the 83-year-old woman with heart disease and arthritis who is an outpatient for cataract surgery. An appeal was made due to the patient's age and medical condition. Was that the rationale for the appeal?

Dr. SPIGGLE. That is right.

Mrs. BYRON. As opposed to a young child?

Dr. SPIGGLE. Exactly right.

Mrs. BYRON. Now, can you give me just a brief scenario on what transpired during that appeal?

Dr. SPIGGLE. That patient was not mine so I can't speak to that particular patient. I can echo what has already been said. When we make the phone call down to Baltimore, and make an appeal, the answer is no, because that agency feels as if it is operating under the same stricture. The question that they ask themselves is, "is this hospital care medically necessary." They are asking themselves in the wrong context, in the context of whether it was technologically necessary, not whether there is a safe alternative.

We feel that you are going to have to change that dynamic.

Mrs. BYRON. In my opening statement, I was touching on the basis of drafting legislation nationally to encompass all categories. This is what makes it so terribly difficult. When you look at a metropolitan area there are alternatives in most cases, but when you look at a rural area those alternatives are not there. In many cases, you are dealing with only one hospital in a community. We are fortunate here that we have several in Allegany County. Garrett County has one hospital. That's it.

You have a limited population. This has already been cited here today in the testimony. In the three counties we are talking about today, almost a quarter of those populations are senior citizens.

Dr. SPIGGLE. Exactly. I agree with you 100 percent. You know, we actually have a drawing area of 60 miles. I was talking to a colleague who is a pulmonary specialist just the other day. It has been his experience and mine that because of these Medicare strictures, we are delaying diagnosis. This is engendering a lot of unnecessary pain and suffering when we can't really get the job done by admitting the patient who lives 60 to 70 miles away to the hospital.

I have here, and I will make it a part of the record, not 3 or 4 cases, but over 40 cases that had been submitted to me by my colleagues in the Allegany County Medical Society. They demonstrate the fact that we cannot expect all patients to comply to Medicare expectations.

[The prepared statement of Dr. Spiggle follows:]

PREPARED STATEMENT OF WAYNE C. SPIGGLE, M.D., ALLEGANY COUNTY MEDICAL SOCIETY

In our area Medicare cost-cutting polices are expressed through a rigid system of regulating payment through certain pre-designed "Diagnostic Criteria". The theory that we can practice effective medicine in compliance with such a system suffers a basic and sometimes "sickness generating" flaw. It is a basic fallacy for the government to expect a sick person to always fit into a previously designed critera in order to have a legitimate illness.

The commonality of concern which brings doctors, hospitals and senior citizens together at this hearing is the awareness that there is something wrong. There is something wrong with the way we are giving health care to the elderly in rural America.

What do I mean by that? In preparation for this hearing my colleagues have collected examples of how quality care is being compromised by Medicare cost cutting policies. I would need an hour to review these cases with you, so I have submitted a compendium for your review, but consider this sampling:

1. A 72 years old man is obligated to have out-patient surgery for a large inguinal hernia and to return to his Frostburg hotel to fend for himself. Thanks to that cost cutting initiative he now has a larger and more symptomatic re-rupture sustained during a fall in the immediate post-operative period.

2. A 77 years old man with uncontrolled abdominal pain is denied hospitalization because the tests which were ordered for him are on the outpatient list. The man is now dead of carcinoma of the pancreas.

3. A 65 years old man with uncontrolled diabetes leaves the hospital because he does not fit the Medicare criteria, only to be readmitted 7 days later sicker from the same illness. The second admission is also denied upon retrospective review.

4. An 83 years old woman with heart disease and arthritis must return home to deal as best she can with her fears just because the Medicare criteria stipulate that across the board, cataract surgery is an out-patient procedure.

5. A 79 years old woman nearing her death from cardiovascular disease knows that she is being admitted to the hospital for the last time. Her limited energies and the energies of her elderly husband are consumed by anxiety over whether Medicare will deny this admission too. I can assure them that no matter what she will be provided with the care she needs, but I have no way of knowing whether her hospitalization will be denied.

I come to you to testify that there are two major mistakes Medicare cost cutting initiatives have created which must be corrected if the elderly are going to have the quality care they deserve.

First, Medicare policies have turned a blind eye to many of the root causes of a person's being sick. When you are at the end of the line with no options because you are hungry or cold or in pain or paralysed or frightened or in other anguish which brings you to a life crisis, you are sick! You may not fit a Diagnostic Criteria but you are sick. But the way we are conducting the affairs of Medicare now, your sickness is not legitimate. Said more clearly, your sickness is illegitimate, unwanted and unrecognized by Federal government criteria. You have a social problem. Social problems do not belong in a hospital. It isn't cost effective.

No matter that your sickness may kill you. No matter that you have no alternatives, that the Social Services Agencies are not equipped to cope with the intracacies of your illness. If you are admitted to the hospital or you are kept in the hospital because there is no other humane way to cope with your sickness, you or the hospital may be at a financial risk for payment because you don't fit the Criteria. This is the crux of a dilemma we face virtually every day in rural America. This is one of the major reasons we are here today.

The second major Medicare Policy mistake which must be rectified is the fact that the patient's doctor has effectively been removed from the decision making equation. The Criteria have become the Bible

we must live by. The doctor's assessment of the patient's true needs has become superfluous. The central issue is no longer the true nature of the patient's needs, but given those needs, how can the patient be made to fit the Medicare Criteria. I can almost guarantee that in the last hour of so somewhere in Western Maryland an emergency room physician and a family doctor have been having precisely this conversatio about a sick patient.

This is no way to conduct the affairs of medicine. If I, as the patient's physician, having made an assessment of the patient's needs, realize that the alternative of hospital care for that patient is to be exposed to being sicker, and if a responsible colleague agrees with my assessment, then I and my patient should have the right to have these Criteria set aside in behalf of good patient care. It is as simple as that.

Right now we don't have that right. Oh yes, there is an appeal process. But is is incomprehensible to most patients and totally unworkable for the practicing physician. We need a prompt, practical bedside solution to all of this bureaucratic razzle-dazzle. Patient care decisions should be made in Cumberland and Frostburg and Oakland, not Delmarva.

There is a solution to this predicament. The solution is to put the patient's doctor back into the decision making equation and to put the CARE back into MEDICARE. The unique needs of individual patients must be given legitimacy. When the patient is at risk to become sicker if hospitalization is with-held, the doctor should have the right and the obligation to present the care dilemma to a physician representing the hospital Utilization Committee. If there is agreement the patient should be in the hospital, the Medicare Criteria should be set aside in the name of good patient care.

I predict that if this adjustment in Medicare policy is accomplished there will be a cost savings to the public. The mountains of costly paper work being generated by the review procedure would be simplified. Average hospital stays would be just as short because of the probability of inappropriate collusion between two physicians responsible to the hospital Utilization Committee is very slim. Appeals to Congressional offices for intervention would markedly diminish. Repeat hospitalizations because of early discharges would be obviated. Best of all, quality of care issues would be effectively addressed.

Thank you for your courtesy and for coming to Western Maryland to consider our views.

[See appendix, p. — for additional material submitted by Dr. Spiggle.]

Mr. BONKER. Let me just add here one more point so that we have a full dimensional view of the problem. When Congress enacts the Medicare Program, or more recently, the prospective payment program, it sets the general policy for administration of a program. It is up to the executive branch then to fully implement it.

I think what we are seeing are early efforts to implement a new program which carries with it some kind of peer review of the services. This may be a little political, but we have a very conservative administration that wants to create savings, by enlarging the Social Security surplus so that the overall deficit doesn't look as bad as perhaps it is. In other words, we are talking about the budget deficit that everybody is trying to bring down.

If you go back and you look at the two different deficit reduction programs since 1980, the bulk of the savings or the expenditure cuts come out of Medicare. One time it was a so-called $16 billion savings, mostly cuts, that came almost all out of Medicare. The second time, called the Deficit Reduction Act, almost all of the so-called savings came out of Medicare.

Administratively, there is an effort to tighten up the criteria to limit benefit payments. I think the people at OMB have clearly identified Medicare as one area where we can produce a lot of savings. The way you do that is by tightening the criteria.

For Congress it represents a dilemma because if we try to get more specific then we remove any effort to be flexible and use discretion down the line. But I think we are dealing with this problem as part of the overall budget dilemma that we in the Congress are facing.

Dr. SPIGGLE. I understand that frustration, but on the other hand if you don't do something we are throwing the baby out with the bath water. We have very definitely saved a lot of money with the new ways of practicing in the outpatient section and so on. Some of that is working well. The problem is that the PRO in Baltimore or anywhere else cannot make a good patient care decision. The patient care decision is best made by the doctor.

Mr. BONKER. I agree totally. In fact, I had always thought that when the attending physician recommended inpatient treatment, that was it, and that was the eligibility test.

Dr. SPIGGLE. I can assure you——

Mr. BONKER. Now, prior to DRG, did the attending physician's word pretty much represent eligibility?

Dr. SPIGGLE. Yes.

Mr. BONKER. That is the way it used to be.

Dr. SPIGGLE. That is the way it used to be. Today I can almost guarantee you that in Western Maryland, there have been at least three conversations between an emergency room physician and a family doctor that went something like this: Look, this patient is really sick; we have got to put him in the hospital, but if he doesn't fit those criteria, what are we going to do?"

Mr. BONKER. I am sure that when Congress enacted this program it was not our intent to drastically change the criteria of procedures for admitting patients. Incidentally, we didn't have a lot to do with it on the floor. It was put in the conference committee between Rostenkowski and Senator Packwood. They somehow came

up with something at the last minute and put this into place. It wasn't something that was heavily debated on the floor.

But in any case, I don't think it was our intent that we drastically change the criteria or the procedures for admitting patients. I think we were looking at instituting a prospective payment system to bring about greater economies. But that is on the other end. That is not on the admission end. The idea was to control more effectively the discharge end.

You have an executive branch that is trying to create all kinds of savings by instituting this new criteria and I don't think the Congress by and large understands what is happening.

Dr. SPIGGLE. I agree with you.

Let me give you only one other insight and then let me stop.

We have in the phenomenon of the PRO, a super structure of another business who is eager to grab Government contracts on the promise that they are going to cut costs. It has been said before, but let me emphasize the PRO is not interested in quality care. They are promising and basing their reason for existence on cutting costs. We need a better check and balance than we have today. Thank you.

Mr. BONKER. That was the largest applause today.

Dr. Jane Fiscus, welcome.

STATEMENT OF JANE A. FISCUS, M.D.

Dr. FISCUS. Thank you.

I am not going to go into some of the details that you all have heard. I am a health officer here in Allegany County, and my reason for testifying today was primarily to acquaint you with the situation in our home health agencies, primarily ours in Allegany County.

I wanted to support, from my standpoint that is, the public side of what you have heard. There is not a piece of Medicare covered service that has not been drastically affected by these new changes in the law. These changes affected a persons getting into the hospital, staying in the hospital, getting into a nursing home, staying in a nursing home, or having home health services either accepted or delivered.

One could not have devised a better system than these folks have done at HCFA to cut costs across the board. They have restricted the services which they will cover, both the nature and the duration. That is kind of it in a nutshell.

Fifteen years ago, there was no home health in Allegany County. Allegany County Health Department started one such service to deliver skilled nursing, home health aid services, nutrition services, social work services, physical therapy, and occupational therapy. Very, very shortly after, the private side joined in at Memorial Hospital Center which began about 3 years later. We have gone along jointly, public/private, in what we think is a very good network.

Our county has probably the best record for total services to the elderly, particularly the frail elderly, of any county I know.

Let me say this: We have a sophisticated medical care system, primary, secondary, and some tertiary. We have a fine emergency

medical system. We have wonderful nursing home beds of high quality. We have some public services available to the elderly for instance, geriatric evaluation services, private home health services, hospice services, and transportation services. We have more day care centers per capita than any county in the State. Ten counties don't have any medical day care for the elderly.

We have got the network. We had it down to a fine art. Allegany County Health Department just got torpedoed in home health. We are shrinking drastically. Let me tell you why and how it happened.

We were delivering on the average of 18,000 visits a year, traveling one-quarter of a million miles. We had about 31 staff members that were well trained and well supervised. The private side was doing slightly more at that point 3 years ago. Sacred Heart has come on line and their visits are climbing rapidly.

Competition was part of what happened. That is OK, because if the private side, in our minds, can handle the problem, then the public side has no point doing it. Our costs were very comparable, however. You think of bureaucracies as being very wasteful. Our costs were very comparable.

Two years ago, the first pebble went into the pool. In an effort to cut costs, the Feds looked around to see urban versus rural designations. We think of ourselves as a rural system. We were designated an urban system, primarily because the service area to the hospitals, which is true. But Allegany County Health Department, the only free-standing home health, the other two are hospital based, and their caps are set for the maximum recoverable by visit on different criteria, got the costs cut down to a cap of about $50 at that point in time by just changing the label.

Now, we don't go into Pennsylvania. We don't go into West Virginia. But, the Allegany County Health Department, was the one that got cornered.

Then HCFA decided to figure the cost of CAP visits in a very different way. I am going to push them together quickly. One, you cannot put all of your costs into one basket. If you have a very efficient system, one will bail out one that is a little more expensive, because of staffing costs, et cetera.

The other thing they did was to compare our costs across the State. We were judged on the basis of what the local staff made, say for example, the staff nurse made. We are a State department. We are paid according to State income, so we are now taking a loss on every visit we deliver.

Prior to that, we were able to cover approximately 20 percent of our population. At any time those who could not pay anything or could afford to pay very little, comprised about 20 percent of our population. This population grew to about 30 percent in the fall because of the criteria crankdown.

We could not feel in our own conscience that we could walk away from these people. These were people who were maintenance, chronically ill folks. We were keeping them in their homes with our care.

So we basically began to look at bankruptcy. State agencies don't go bankrupt. It goes down the next way. We went to the county commissioners to ask for help and described the situation. They de-

cided they would help us, indeed, while we scaled down and invented another service. Now if this is what you anticipate happening everywhere, it won't happen.

We did meet the need. We took some of these people out into a less restrictive area at least from the standpoint of paperwork which had ballooned. The denial rate went up and somewhere around $120,000 of our approximately $450,000 is currently being tinkered with. We are not allowed to have it. We are not allowed to collect it until they get through scrutinizing it.

Records are being sent back for each patient that we ask about. They deny it. It is the demise, perhaps, of our agency. When that happens, the maintenance-type people will have to go, unless we can find another funding source.

These homebound, extraordinarily ill people will not be maintained in their homes, where they are happy and where they are being maintained at an average cost of $3,500 a year. A nursing home is $18,000 a year in this county. Home is where they want to be, and that is what it is going to take to keep them there. We may not be able to find the money to do it. Thank you.

[The prepared statement of Dr. Fiscus follows:]

PREPARED STATEMENT OF JANE A. FISCUS, M.D., HEALTH OFFICER, ALLEGANY COUNTY

Allegany County in Western Maryland has a population currently of approximately 77,000 people. 21% of the residents are 60 years of age and older. This is the predicted proportion of elderly in the U.S. in the year 2030. 18% have incomes of 125% of poverty level or below. Only 2% of the residents are non-white. Cumberland, the county seat, has 23,000 people and except for this area, the rest of the county is largely rural and mountainous.

The medical care system is rather highly defined and developed. 150 physicians practice in the area. Two large hospitals and one small one serve acute care needs. Primary, secondary, and some tertiary care are provided within the county. The Trauma Center with Medivac helicopter is available. Six nursing homes serve the area with approximately 650 beds. Three home health agencies, two based at the larger hospitals and the Allegany County Health Department, provide Home Health Care services. Thomas B. Finan Center provides comprehensive psychiatric and inpatient services for mentally retarded, drug and alcohol treatment for adults and adolescents.

Over the last two years, changes in Medicare benefits have markedly effected the elderly's ability to access needed care. Health Care Financing Administration's, cost containment maneuvers have changed admission and discharge criteria for acute care hospital systems, admission criteria for nursing homes, and eligibility for home health skilled nursing services. The impact on acute care hospitalization was obvious. Length of stays diminished: empty bed percentages increased. One day surgical procedures were the vogue. Nursing homes favored the admission of higher skill-level care patients instead of the intermediate care patients. Home health care patients became more severely ill and required higher levels of care and higher technical abilities for the home health care agencies.

Home health care eligibility changed drastically. Not only must the patient be in need of skilled nursing services and be homebound, but the intermittent care rule was instituted. This rule stated that the home health services can be provided on a daily basis, a maximum of one to two hours, for only a short period of time (usually two to three weeks). Rare extensions are made and these are often short, e.g., one to two weeks. Documentation is required which is much more difficult than formerly. Emphasis is on the delivery of skilled nursing assessments and care and the education of patients or care givers.

Allegany County Health Department had established the first home health agency in the county in 1971. Memorial Hospital followed soon after and Sacred Heart Hospital about three years ago. In a period of eight years the home health

agencies in Maryland went from 32 to 177. Competition was fierce. Reinbursement crackdowns have come one after another over the past two years. The first was a change from rural to urban designation, (because Cumberland serves approximately 300,000 people in its medical system). Cost caps calculations were changed so that free standing agencies such as the Allegany County Health Department became less competitive. The cap for nursing visits by the end of 1985 was $48 per visit; the actual cost was $56.00. Allegany County Health Department was assigned the lowest cost caps in the state. It should be mentioned that these caps were computed on the going rate of costs for staffing in the county. Allegany County Health Department employees are paid on the statewide Department of Health and Mental Hygiene level. Appeal of this cap determination was begun November 1985 and is still in process (May 1986), with the intermediary BC/BS of Maryland. A timely movement from the intermediary to H.C.F.A. and a favorable result could have moderated F.Y. 86's budget deficit. Cost calculations for all of the multi-discipline professional staff were changed from aggregate costing to individual discipline costing, thereby cutting our ability to spread costs for one service over into the other services. In March of 1986, Gramn-Rudman cut another 1% in Medicare reimbursement.

Prior to F.Y. 86 Allegany County Health Department had served as the primary gap-filling service for those unable to pay or without third party coverage for home health services. The average rate of those in our patient population was from 18% to 20% at any time. We were able to supply these services by careful cost containment within the department and by spreading allowable reimbursements over services for those who were unable to pay. In 1984 we delivered 18,000 home health visits via all disciplines including 9,000 skilled nursing visits. Staff traveled 250,000 miles. With the cost crackdowns other available home health agencies have maintained admission and discharge criteria to those of Medicare. They clearly say to the patient "We can serve you as long as skilled criteria, determined by Medicare is met, after that we cannot supply this service". Often these patients and their families sought services from Allegany County Health Department's home health department. By August of 1985, no-pay percentage patient load here had risen from 20% to 33%. As over-all patient load fell, this became impossible to manage. 70% of the patient load is eligible for Medicare services, but visit denial for payment increased dramatically. At this time (May 1986), $120,000 of patient services is being questioned by BC/BS of Maryland for Medicare reimbursement. The total service delivered for F.Y. 86 is projected to be $400,000. Nursing visits will be approximately 6,000; total visits, 11,000 for F.Y. 86.

Allegany County Health Department has developed a new system of care, Adult Nursing Supervision, to care for some of these patients at a less costly rate. This involves aide services for personal care, assistance with daily activities, and intermittent nursing visits (once or twice a month). By moving these patients

out of certified home health services, we are able to deliver nursing visits at $30.00 a visit and an aid visit at $20.00. Many patients are being referred to this service from Allegany County Health Department Home Health and by the other Home Health agencies.

Let us describe some patients involved who are no longer covered by Medicare: PATIENT IT - Age 56 - Cerebral Palsy. Needed services: aide twice a week, a nurse once a month. Condition - multiple contractures, completely bed ridden, must be lifted from bed to wheelchair and fed. A bath is required twice a week. Income SSI: $372/month. Total caregiver - mother - age 76 with an income of $378 per month. This is obviously maintenance care and is no longer covered by Medicare. Without the help of aide and nursing services and the support the mother gets from this agency the daughter would be institutionalized. The services required could be delivered at total cost annually of $2,580, as opposed to an institutional cost of $18,000 per year.

PATIENT LR - Age 65 Severe Rheumothoid Arthritis. Needed services: aide three times a week, nurse once a month. Condition - bedfast for 40 years - severe limitation of movement of arms and legs with contractures, and deformities; can't turn in bed. He is over-weight needs help with bathing and changing. Income - Social Security $338/month. Ineligible for medicaid. Sole caregiver is sister in her 60's who is unable to lift or totally care for this man because of his size and deformities. Without support he certainly would require nursing home. Cost of care for this patient to our agency annually $3,900.

PATIENT HK - Age 85 - Diabetes Mellitus with severe foot ulcer (exposed bones of foot). Needed services: daily home health nursing visits for wound care. Condition - wheelchair-bound because he is unable to bear weight: threatened amputation if healing could not be facilitated. Income - Social Security $372/month. Caretaker 80 year old wife who was not able to be taught wound care. Outcome: after several months of treatment, the ulcer was ready for skin graft and finally healed slowly. Visits for nursing care were billed to Medicare but 59% of the visits were denied. Reason given for the denial-elderly wife should have been taught to do the wound care. Although education was attempted, she was unable to manage this complicated nursing task.

These case histories are not atypical. In December, 1985, Allegany County Health Department collected 35 such case histories. In this group, the median income was $5,7000 annually per household. 77% of these patients were food stamp eligible. The cost of delivering Adult Nursing Supervision program to these patients is approximately $3,500 per year per patient; few can pay any portion of the fee. It seems obvious that some system allowing home health agencies or other service agencies to deliver such services should be considered. Certainly, $3,500 versus $18,000 a year nursing home costs is a striking saving. If such support can keep these people in their homes where they wish to be, we should address this need.

Office on Aging, State of Maryland, has examined the needs of the elderly and established priorities for meeting these needs. Rosalie S. Abrams, Director, Office on Aging, in her Statement of Priorities 1986 notes there is a "lack of sufficient affordable community based long term care". The range of services provided to persons who have difficulty with basic activites of daily living, includes bathing, dressing, eating, and mobility and is delivered in a variety of settings from intensive in-home services to homemaker assistance and respite care. This situation prevents the elderly with chronic disabilities from remaining in their own home and encourages premature institutionalization. The strategies noted by the Office on Aging for implementing this priority of increased long term care services in the community are:

1. Extension of the Gateway II model statewide. Extension includes interagency planning, systematic case management, and gap-filling services dollars to add more counties.
2. Expansion of selected categorical programs, especially programs that offer personal care and in-home aide services, including respite care, and day care.
3. Continuation of interagency planning at the state level, aimed at a more unified budgeting and planning for public services for the elderly.
4. Exploration of new private funding mechanisms, including private long term care insurance as payment sources.
5. Continued exploration of other public funding sources, including waivers and capitation plans.
6. Exploration of the need for and feasibility of a pre-admission screening/assessment activity to determine the most appropriate setting for care.

Allegany County Health Department supports the Office on Aging priority statement, but Gateway II for Allegany County will be approximately $60,000/year in purchases of services. No staffing monies are included for case management in the Health Department. For F.Y. 87, we are anticipating a need of $120,000 to $140,000 to purchase many of these services even at the lesser rate in our nursing supervision services.

It should be noted that local county government has strengthened the funding for these services in this fiscal year. Shortfall was so precipitous in F.Y. 86 that $60,000 was added to the Health Departments budget to continue these services to the frail and elderly. Local funds are limited in this county and cannot possibly cover the need if the need continues to escalate.

Federal responsibility to help with these problems cannot be totally denied. A few well spent support dollars with high quality supervision can keep these frail elderly in their homes and out of higher level of more costly care. Appropriate intervention in these situations becomes true prevention and cost containment.

Mr. BONKER. Thank you. We will now call on Sister Cecilia.

STATEMENT OF SISTER CECILIA

Sister CECILIA. It is very difficult not to repeat some of the comments that have already been made because they are very important to the essence of this conference. We are very happy to participate and we appreciate the need for cost containment. However, I believe that the cost containment effort has gone too far in terms of reduction for benefits for patients.

At any one time in our hospital at least 55 percent of our patients are Medicare patients, so we deal with this problem significantly. As has been pointed out, the admission denials, as well as State denials are the two areas that we are seeing over and over again.

I believe that these criteria should be guidelines, they are rigid. I do not believe they should be the absolute. I think that the doctor should have the ability to make judgment on their patients. Both the social condition and other factors that may not appear on these particular criteria should be considered. I think we should not be judging these strictly by the criterion.

The other things that it fails to take into account are the chronic illnesses and handicaps that many elderly people have. As has been said, an 85-year-old person is not necessarily the same in health as a 65-year-old person. Patients are expected to have many procedures done on an outpatient basis including surgery. Many of these procedures require some preparation prior to the surgery.

Many of these people cannot perform these procedures on their own, and yet, home care cannot cover this kind of care. Routine followup care may not be possible for patients at home. A simple procedure such as cataract surgery requires eye drops every 4 hours. Home care would not be paid to come in and provide this care, yet many of the elderly patients cannot do this on their own. Then may not have a care giver to provide it.

The continued stay denials are extremely painful on patients. We are required to give patients the information in a letter when their continued stay is going to be denied. It is extremely hurtful to the psychological well being of patients. We have a shortage of nursing home beds in Allegany County, so it is not always possible to move the patient into the nursing home.

As has been said, many times people could be taken care of on a home-care basis, but chronic illnesses are not recognized. The patient has to be in a recovery stage or in a declining state. If they are stable they are not covered for care. Let me give a few examples; I have many, too. Patients are confused when trying to understand all the forms that they have to fill out and the conditions upon which they will be paid. One gentleman, aged 66, was overwhelmed by the bills and statements after his hospitalization. "This is not a bill," was printed on some statement. The complexities of primary and secondary insurance, along with the forms, bills, and statements was overwhelming. He told the social worker, "I'll just go home and shoot myself, and then I won't have these problems."

A lady, aged 75 was wheelchair bound. She had a sigmoidoscopy done on an outpatient basis. Following this exhausting rectal procedure, she was simply not able to go home so she was admitted to the hospital. The admission was denied.

A man, aged 69, from an outlying hospital, was brought in for consultation for possible arrhythmia. Because of the distance he came, he could not be sent home. He was admitted for evaluation. The admission was denied, although the arrhythmia was confirmed.

A lady, aged 66, had repeated hip dislocations and was in traction. Her continued stay was denied, because the patient was stable, yet she could not be placed in other setting and there was no care giver at home.

Another lady, an 81-year-old stroke patient, needed physical therapy and rehabilitation. She was eligible to receive the rehabilitation in a nursing home but there was no bed available. Her continued hospital stay was denied.

These are just a few examples of many, and we hope that you will take them under serious consideration. I would just quote two of our recommendations. Many of the injustices could be avoided by giving more consideration on a timely basis to the exceptions where cases fall outside the guidelines or criteria, and are based on the physician's judgment.

In other words, give physicians more discretion in designating the proper care of their patients, without strict adherence to uniform, rigid guidelines.

Second, additional levels of care could be established to assure the care is continuous at an appropriate level, yet not overintensive. For example, payment for a subacute level of care within the hospital setting could be appropriate.

Also, better coverage of home care is needed.

I think this is all that I will quote at this point in time, but we are encouraged by the fact that you are having this hearing. We hope that you will take into consideration all the many comments that we have made here today. Thank you.

[The prepared statement of Sister Cecelia follows:]

PREPARED STATEMENT OF SISTER CECILIA, PRESIDENT, SACRED HEART HOSPITAL

I am Sister Cecilia, President of Sacred Heart Hospital, Cumberland. We are a 240 bed acute care hospital. In 1985 40% of our inpatients were beneficiaries of the Medicare program. However, because Medicare patients, on the average, stay in the hospital longer than other patients (10 days versus 7.2 days), 55% of our patient-days are Medicare beneficiaries. In other words, on an average day, over half of our patients are Medicare.

This illustrates the significant impact of the Medicare program on our hospital.

Recent changes in the Medicare program, specifically, the transition to a prospective payment system and the various measures taken to reduce the overall costs of the program, have had a devastating effect on the beneficiaries. Denial of benefits can be classified in two areas: 1) admission denials and 2) continued stay denials.

Although most insurance programs do not cover hospital admissions for diagnostic reasons, there is a large gray area affecting the elderly in which the patient is obviously sick; however, a definite diagnosis has not been determined.

Many hospital admissions are denied because the procedure required can be done on an outpatient basis. Many outpatient procedures require preparation as early as the day before, which the patient is supposed to perform at home. In the case of many elderly patients they are unable to do this. Also, following outpatient procedures, elderly patients are more apt to require a longer recovery and are simply not able to return home the day of the procedure. Even routine follow-up care can become a problem. For example, the administration of eye drops after cataract surgery, which must be done every 4 hours, is simply impossible for many elderly patients.

The continued stay denials, which occur when a patient is reaching the end of his or her allowable number of days, can be particularly difficult for an elderly patient. Although patients may not require continued acute care, the alternatives they face are not always appropriate. With the shortage of nursing home beds in our area a person who needs nursing care can hardly be expected to go home and wait to be admitted to a nursing home. Yet this is happening.

These problems can be compounded in a rural setting where distance becomes another factor.

Changes in the program have affected physicians, who are becoming more and more reluctant to take assignments. This puts the burden of claims filing on the elderly patient. The uncertainty of whether a physician is or will continue to take assignments adds to the confusion of the elderly.

Here are some recent case histories that we have observed:

1. Mr. R.M. - Age 66, after his hospitalization, was overwhelmed by his bills, statements stating "This is not a bill" and the complexities of primary and secondary insurance. He told the social worker "I'll just go home and shoot myself and then I won't have these problems."

2. Mrs. K.M. - Age 75, a wheelchair bound patient, had a sigmoidoscopy on an outpatient basis. Following this exhausting rectal procedure, she was simply not able to go home, so she was admitted to the hospital. The admission was denied.

3. Mrs. N.M. - Age 75, a patient with a psychotic problem, was refused admission at the State Mental Hospital. Unable to live alone, she was brought to our hospital and admitted. The admission was denied.

4. Mr. D.L. - Age 69, was sent in from an outlying hospital for consultation for possible arrythmia. Because of the distance he came, he could not be sent home. He was admitted for

evaluation. The admission was denied, although the arrythmia was later confirmed.

5. Mrs. L.D. - Age 66, had a repeated hip dislocation and was in traction. Continued stay was denied because the patient was "stable," yet she could not be placed in any other setting.

6. Mrs. M.S. - Age 81, a stroke patient, needed physical therapy and rehabilitation. She was eligible to receive this care in a nursing home; however, no bed was available. These services are not available on a daily basis from Home Care, yet her continued hospital stay was denied.

These last five examples are cases where the hospital had to absorb the cost of care because Medicare denied payment.

We wish to submit these recommendations to reform the Medicare program.

1. Many of the injustices could be avoided by giving more consideration on a timely basis to the exceptions or those cases that fall outside the guidelines or criteria, based on the physician's judgment. In other words, give physicians more discretion in designating the proper care of their patients, without strict adherence to uniform rigid guidelines.

2. Additional levels of care could be established to assure that care is continuous at an appropriate level, yet not over-intensive. For example, payment for a sub-acute level of care within the hospital setting would be appropriate. Also better coverage of home care is needed.

3. To reduce the cost of the program, a "means test" could be adopted.

4. Additional effort should be made in education, so that beneficiaries have a better understanding of the system and are not overwhelmed by it. Of course, a simplified program would be more easily communicated.

Once again we thank you for the opportunity to give you our thoughts on these matters.

Mr. BONKER. Thank you, Sister.
Mr. McAneny.

STATEMENT OF DONALD McANENY

Mr. MCANENY. Chairman Bonker and Representative Byron, I will summarize very quickly. We are both an acute care hospital, and a home health agency. Our part of the testimony was as much as anything directed toward the issue of continuity of care, which you have heard quite a bit about. Let me be precise in terms of what those recommendations are.

The implementation of utilization controls, has increased the number of elderly patients who require convalescent care outside of the acute-care setting. They used to receive this care in the hospital. Now the demand has increased 50-fold.

The problems facing convalescent patients, such as their frailty, lack of transportation, and all the other reasons, are compounded by the fact that fiscal intermediaries in this state, interpret regulations. It is not that regulations or laws, have changed in the most recent 3 years. It is the interpretation of those regulations. As those regulations become more and more strict, they become less and less beneficial to the very patient and very population we are trying to deal with.

So, therefore, you have got a list of examples which go on the record. They are common and similar to what you have already heard. Let me just maybe summarize what we think would help solve some of the problems.

First of all, since the intermediary is subject to contract by HCFA, I think that HCFA can direct the intermediary to cease the strict interpretation, by allowing judgment on the part of the provider. The physician or the home health agency in combination with the physician look at alternatives. What is the cost benefit in that particular situation? Can, in fact, maintenance care be provided that is not interpreted as skilled care on an intermittent basis in the home?

Second, I think that perhaps the introduction of a voucher system could be a first step since Congress is concerned about the overall cost of care. The voucher system could permit, the trading of skilled nursing home benefits. These benefits are already limited, but at least the trade off of these benefits would provide alternatives at the homesite.

These alternatives can include such things as drug therapy that is not included now, or respite care. Short term followup care for post surgical patients could also be included. Hotel type of accommodations could be included for overnight stays in the hospital that would enable a patient to receive outpatient care in a comfortable surrounding with support. Some sort of tradeoff system would not initially be a threat, let's say, to the deficit targets of Congress and the President, but could provide those tradeoffs.

You should realize that no comment has been made here about the inadequacy of skilled nursing care benefits. Those, too, are extremely restrictive. Many patients cannot even get into a skilled nursing home because they do not meet Federal requirements. The same things happen at that level too.

If the Office of Management and Budget has created substantial savings in the Medicare system in the past 2 years, which it should have since statistics and utilization rates have dropped 17 to 25 percent, then we should find out how we can hold them accountable. If they have reached their target, fine. But, if they have exceeded the target, why cannot those dollars be turned back into the alternatives that all of us here today have already talked about. These alternatives are the different levels of care. Why can't those same dollars be turned right back into serving the very people that the Medicare Program was originally intended to serve, but only in a different way.

Basically, those are the three suggestions we have. We hope, again, as everyone does, that your efforts will not go unheeded and our comments will not go unheeded. We hope that the very patients and people we serve will not be faced with continued threat of economic loss, dignity, and loss of even their own property.

Thank you very much.

[The prepared statement of Mr. McAneny follows:]

PREPARED STATEMEIIT OF DONALD C. McANENY PRESIDENT, MEMORIAL HOSPITAL AND MEDICAL CENTER OF CUMBERLAND, INC.

I am Donald C. McAneny, President of Memorial Hospital and Medical Center of Cumberland, Inc., a regional medical center serving a three state area. Thank you for the opportunity to testify before the Select Committee on Aging.

The Memorial Hospital and Medical Center of Cumberland, Inc., as a vital part of the (our) community, has been concerned with meeting the medical needs of the (our) population in this tri state area. We look with care and concern toward meeting these needs, in particular, the needs of the elderly and take this opportunity to voice our concerns as well as presenting suggestions for addressing some of these needs.

As you are aware, there have been numerous changes within the health care delivery system. DRG's and utilization review are terms mentioned synonymously with health care. For clarification, it should be noted that Maryland hospitals are not paid by DRG's under Medicare. If there is physician documentation of the medical necessity for continued hospitalization, the patient may stay in the hospital and the hospital will be paid. This is the preferred method and hopefully Maryland will be allowed to maintain its "waiver".

Changes affecting the health care delivery system include universal utilization review, which is mandated by state law, and is an ongoing medical review process to ensure appropriate use of resources in relationship to the patients' medical needs. Utilization review has contributed to the control of health care costs which, until recently, have been escalating rapidly. Now, however, the rate of increase has been greatly reduced and most of this has been accomplished by a reduction in hospital length of stay along with incentives to change to outpatient services instead of hospitalization. To accomplish this reduced length of stay has meant the physician must be more intense in his diagnostic workup and must work under a certain degree of pressure to make the diagnosis as quickly as possible and start therapy immediately.

However, this process has not been without its complications and negative results. Previously, the elderly patient would often convalesce in the hospital; now, as soon as the patient is stable, convalescence be accomplished at home or elsewhere. In many cases, the elderly have a more difficult convalescence because of frailty, lack of transportation and longer recovery times than their younger counterparts. Unfortunately, changes to prospective payment did not consider this need. We will address this issues in more detail later as it relates to continuity of care.

On the other hand, we can find no evidence that decreased length of stay has compromised quality. Memorial Hospital has experienced a reduction in the elderies average length of stay to approximately 8.5 days over the past two years. This has been realized without compromising the quality of patient care, as supported by recent studies through our quality assurance office. These studies show that readmission rates have actually been reduced by 50 percent and have remained constant at this rate for the past 18 months. The studies initially looked at readmissions to the hospital within a one week period for medical problems related or similar to that requiring the first hospitalization. These studies were implemented to assess if the quality of care was being adversely affected

by earlier discharges. These studies revealed no adverse affect to the quality of care even when the time frame on readmission studies was lengthened to first two weeks and then to one month. These inhouse studies compare favorably with similar national studies.

With the reduction in the length of stay, one must look toward home health services as one means of providing continunity of care and meeting the needs of the discharged convalescing patients. However, questions on funding and payment must be resolved before maximum benefits of home health care can be realized.

While changes in regulations governing Medicare payment for home health service has been minimal for the past several years, interpretation of these regulations by fiscal intermediaries has changed frequently. These changes in interpretation have made home health service available on amuch more restrictive basis.

Since July 1, 1981, to qualify for home health benefits under either Part A or Part B of Medicare, a beneficiary must be confined (homebound) to his or her home, under the care of a physician and in need of skilled nursing services on an intermittent basis, physical therapy, or speech therapy (HCFA-Pub.11.) The following are acutal examples of rigid and narrow interpretation of regulations and governing medicare eligibility criteria and are counterproductive to continuity of patient care. In some instances, the interpretations actually end up costing the Medicare program more money.

.isted below are specific examples of problem areas.

1. HOMEBOUND-

Mrs. T., a 78 year old female, was referred to Memorial Hospitals Home Health Service with a diagnosis of pneumonia, malnutrition, metastatic cancer, mild congestive heart failure and arthritis. She lived in a first floor apartment located on hilly terrain. It would have been medically, socially and psychologically beneficial for the patient to have limited supervised ambulation to keep her at an optimal level of functioning and to prevent complications of immobility. This patient would have been an excellent candidate for Memorial Hospital's free "Mall Walk' program. This hospital's home health van, equipped with a hydrolic lift, could have picked Mrs. T. up at her apartment and delivered her to the mall where she could have walked at her pace, under supervision, in a controlled environment and out of inclement weather. Had this patient enroled in the "Mall Walk" program, she would have become ineligible for Medicare reimbursement of home health services, since she then would not havemet Medicare's definition of "homebound."

INTERMITTENT - Skilled

Example A -

A 74 year old female was in Memorial Hospital from February 5 to April 6 several years ago. She had a right subcutaneous hemi-mastectomy plus a modified radical mastectomy on the left and the right side. .She developed an area of skin necrosis over a portion of the skin graft and increased drainage on the left thigh (donor site) and right chest. The cultures revealed a staphlaccous organism necessitating hospital placement in isolation.

Her discharge was dependent upon Home Health follow-up. She lived alone. The physician felt she could get professional care at home from Home Health nurses. The Home Health nurse saw the patient the day she was discharged from the hospital and began seeing her two times a day until May 16. At that time, visits were reduced to once a day per physcian's orders.

This patient had 49 nurse visits in April. Her bill for home health services that month, including laboratory fees, amounted to $1,325.38. The May bill amounted to $1,135.55. Nursing home facility costs in our area at that time ranged between $1,200 and $1,500; but there were long waiting lists for each facility and nursing home was not a viable option because of unavailability. Additionally, had the patient gone to a nursing home facility; she would have forfeited her personal integrity as well as having to dispose of her personal belongings and apartment. The patient would have experienced a loss in her decision making process, loss of self esteem and privacy, cultural shock, and isolation. Once her apartment was gone, chances would be slim she could get a similar one, plus her community support system would be gone. As it was, she was able to maintain herself in her apartment after Home Health discharged her and she was able to function independently, and maintain her self-esteem and dignity.

Under today's interpretations, she would not have been eligible for the Home Health benefits.

EXAMPLE B-

A 71 year old female was a diagnosis of diabetes mellitus and diabetic neurotrophic plantar ulcer needed foot care daily. She was obese making it very difficult for her to do the foot care herself. The care needed was not considered skilled care under Medicare guidelines. She sold her home and after trying several different living arrangements entered a nursing home where she could receive the care required. At that time, the rest of her belongings were sold. The lady is now ready to leave the nursing home and is seeking help to procure adequate <u>furnished</u> living quarters. Mrs. H. claims that she has no equipment to set up housekeeping and does not have the financial resources to purchase household articles. The HIFCA publication "H.I.M." states:

"Although most patients require services no more frequently than several times a week, Medicare will pay for part-time (as defined 5206.6) medically reasonable and necessary skilled nursing care seven days a week for a short period of time (2-3 weeks). There may also be a few cases involving unusual circumstances where the patient's prognosis indicates the medical need for daily skilled services will extend beyond three weeks."

III. MUST BE SEEN BY A PHYSICIAN EVERY SIXTY DAYS -

Mrs. W., an 89 year old female with squamous cell cancer with metastasis to the left mandibular space, organic brain syndrome with an indwelling foley catheter for urinary incontinency. This patient's tumor of the left mandibular area extended to the right side of her chin, appeared very raw and bled freely with dressing changes. Bleeding was profuse at times and it was feared that the bleeding could not be stopped because of the extensive tumor. Daily nurse visits for dressing changes were ordered because of the bleeding and hemorrhage potential. The patient was transported via the Home Health van, equipped with a hydrolic lift, as long as the patient's condition tolerated, then an ambulance would have been required. The ambulance would have cost $40 each way; a total of $80. The physician's office could not accommodate an ambulance gurney, therefore, the patient would have to be seen in the Emergency Department, an added cost. The physician was not doing aggressive treatment, just management, and was very comfortable with the Home Health management and reporting systems. An upper airway obstruction was a real concern.

The fiscal intermediary questioned the fact that the patient was not seen by a physician every sixty (60) days. Should the patient have been

transported by ambulance to the Emergency Department just to meet the fiscal intermediary's interpretations of Medicare guidelines? One must look at the physical trauma to the patient as well as the added cost.

IV. REIMBURSEMENT FOR ANTIBIOTIC THERAPY -

Mrs. D., a 65 year old female, was hospitalized and treated for staphylococeal bacteremia, sensitive only to Vancomycin. Her medical history was significant for lymphocytic lymphoma, bronchiectosis, adult unset of diabetes mellitus, and status post placement of Hickman catheter for vascular and chemotherapy access. The I.V. antibiotic therapy would require four weeks to administer and she could have been discharged to her home with Home Health intervention as needed. The plan was to send her home, thus saving the costly hospitalization. However, there was no reimbursement for the daily Vancomycin which costs $28.41 per dose and was to be given four times a day at a cost of $113.64 every day. The patient could not afford to pay the $3,181.92 for the four week supply of the antibiotic, Vancomycin. Therefore, the patient remained hospitalized which was more expensive than if the antibiotic had been paid for by Medicare.

Very restrictive interpretation of Medicare guidelines no doubt results in some cost savings of Medicare dollars for home health services. Are these dollars truly saved if these patients are forced into other areas such as nursing homes?

If Memorial Hospital had followed these Medicare guidelines, one of these patients would have gone unnecessarily to a nursing home, severed all community ties, lost personal integrity and self esteem. Instead, the hospital picked up these costs! But, how long can one continue doing this in a program where the money supply gets tighter?

The medical needs of the patients in these examples were real and could not be met satisfactorily within strict interpretation of the Medicare criteria for the existing programs. Possible inexpensive remedies for some of these problems could be found with adequare funding of support services such as respite care, sheltered housing, pharmaceuticals at home, personal care and transportation.

Funding for suppport services like respite care might be found through a voucher system approach in which,for example, two skilled nursing home health visits would equate to one day of respite care.

Third party payors are encouraging the use of outpatient or ambulatory settings for certain surgical and diagnostic procedures. The age of the patient is not determining factor for determining when these outpatient procedures are appropriate. This raises concerns about the elderly patient who must return home following the procedure without benefit of a support system in the home.

If these patients meet the eligibility criteria, home health may be an alternative for limited follow up to ensure the patients well being. Remember, however, medical necessity is one of the criteria which must be met in order for these services to be covered by Medicare. The fact that a patient lives a distance from the facility, has difficulty traveling, or some degree of mental impairment preventing them from following directions does not presently constitute medical necessity and, therefore, Medicare will not approve payment since the eligibility criteria is unmet.

Another viable alternative for meeting the needs of the elderly is the swing bed concept. Federal regulations provide for utilization of swing beds which to this point the state of Maryland has been unwilling to endorse even though other states have demonstrated this concept is cost effective. Provision of a mandatory condition related to allowing use of swing beds and receipt of federal monies is a way in which representatives could influence the state's decision on the use of swing beds.

Other changes in the Medicare program have occurred and ,though not recognized by the patients as directly affecting them, there is an impact. These changes are in the area of documentation review and billing reviews. In September, 1985, HCFA initiated for Home Care new recertification letters and billing forms consisting of three pages. The three forms replaced a one page form, basically a check list, utilized by Home Health agencies in Maryland, Form 16.4. The 16.4 form required 20-30 minutes to complete. The new forms require minimally 45 minutes to complete and a maximum of one to one and one-half hours to complete. These forms are required on every new Home Health admission and every sixty days thereafter.

In March 1986, our Home Health Agency completed 102 billing forms and 34 recertification letters.

136 forms x 45 minutes = 6120 ÷ 60 = 102 hours
136 forms x 90 minutes = 1224 ÷ 60 = 204 hours

Implementation of these forms is very expensive for agencies and impacts on their ability to be cost effective under capped levels of reimbursement.

Administrative and operating costs are also increased because of the intensive review of patient bills by Medicare and other third party payors. This review often requires the expenditure of more staff time in both medical records and billing departments. This review creates a delayed payment situation which encompasses all patient services. Frequently, a question related to a $100 radiology charge means delay in payment of $10,000 bill. Why not pay in a timely manner that portion of the bill not in question?

These payment delays affect the facility's ability to operate efficiently and receive discounts which are available for timely payment of bills. This additional operating expense occurs at a time when reimbursement has been capped and prevents efficient use of financial resources.

The recent change in scheduled payment by Medicare of Periodic Interium Payments, otherwise known as PIP, has also impacted the facility's ability to address recognize commnity needs. Delay by Medicare in making these payments also contributes to an increase in operating expense which affects the facilities ability to institute new programs. These delays in Medicare payments occur following a historically low census, which means cash flow will be adversely affected when need is greater. The delays occur at the end of the federal fiscal year and occur for the government's benefit.

The concept of DRGs, implementation of utilization review intensive billing reviews, and adjusting to changes in PIP are but a few changes impacting the health care system. Memorial Hospital will continue to adjust to these changes while assuring our community the highest quality of patient care. We request that you consider carefully the problems identified as you participate in the regulatory process for programs which will affect us all, but in particular the frail elderly.

Thank you for the opportunity to voice our concerns.

Mr. BONKER. Thank you. Anybody else on the panel have a comment before Mrs. Byron poses some questions? Our local dentist, John Davis. You practice here in Cumberland?

Dr. DAVIS. Yes, sir.

STATEMENT OF JOHN S. DAVIS, D.D.S.

Dr. DAVIS. Just a comment. I think there may be a misconception. There are no provisions for dental care under the present Medicare program, and I am sure that the committee is aware of that, but I didn't know whether you were or not.

Another comment I wanted to address is that while dental treatment may be expensive, I think a good preventive program would not be. I think that it may be good to look into this area.

The last statement I want to make is the fact that Medicare will not pay for the hospitalization of many patients who cannot have their dental needs attended to in any other manner. Now, this has gone through review. It has been considered a humanitarian act and not essential. There are many people that cannot have dental care carried out in the dental office, especially the elderly. They have to be hospitalized.

That is all I have to say.

[The prepared statement of Dr. Davis follows:]

PREPARED STATEMENT OF JOHN S. DAVIS, D.D.S., CUMBERLAND, MD.

GERIATRIC DENTAL PATIENT CARE

There are no provisions for dental care under the present Medicare program.

It is a fact that medicare will not pay for hospitalization for many patients that can not have their dental needs attended to in any other manner - Medicare medical officers (physicians) make decisions on patients having no first hand knowledge of the patient's needs. Therefore, the conclusion can be made that not only does Medicare not pay for dental care, but is an obstacle for some.

Medicaid does pay for emergency treatment as long as it is extraction of teeth. This program for the elderly is not much better than Medicare.

The State of Maryland tried to pass a law, which did not pass, to allow a dental hygienist to perform her duties in institutions (nursing homes in particular) without direct supervision of the dentist. The pros and cons of the law can be debated, but I submit to you that a change in federal regulations to have the dental need of the institutionalized patient attended to ona daily basis by aides or other staff members would improve the dental health of these patients more than 100 percent.

I personally have offered to set up a preventative dental program at no cost to a local nursing home. The staff was unwilling to work with this idea on any level. They feel that they are now overworked. This would be one more task and they would be paid no additional monies. I think a restructuring of the regulations could easily remedy this dilemma.

By the year 2000 there will be 2,000,000 nursing home patients. By the year 2030 there will be 3,000,000 nursing home patients. Over 20 percent of Americans over the age of 65 will spend a portion of their remaining years in a nursing home (about 80 percent will not - geriatric voting populations). Over 65 percent of nursing home patients are edentulous (without teeth) and 83 percent of all the nursing home patients need immediate dental care of some type.

The staff and patients of nursing homes are unaware of their needs and therefore do not seek treatment.

It is a fact that the geriatric population is growing geometrically. This is a new frontier in all the health services. Dental needs are to be included in the holistic approach to these patients for this population to be healthy emotionally and physiologically.

The geriatric population is demanding quality care and the demand is growing rapidly. Let's get prepared to meet this demand.

Mr. BONKER. I think those are relative comments, Dr. Davis. Thank you.

Congresswoman Byron, any questions?

Mrs. BYRON. Let me get a little comparison here because we have had testimony from Garrett County and Washington County. One of those counties, Washington County, stated that 40 different groups were doing insurance reviews on their hospital patients. Only in one instance was a case denied by a private insurance group, whereby I think they had 51 cases cited by the PRO. What has your percentage been? Is it about the same? You obviously are being reviewed by an equal number of agents from independent insurance companies, as compared with the PRO?

Mr. MCANENY. You are going to find that it varies from hospital to hospital, obviously. Up until recently, the denial rate for Medicare at our hospital was less than 1 percent.

Mrs. BYRON. That was up until just recently?

Mr. MCANENY. Yes, the system has changed again. There is no longer a count, if you will, a percentage of denial.

Mrs. BYRON. Well, Garrett County said that they had 17 denials in one quarter. Washington County said that they had 51 in the last year. Would yours be escalating to that number?

Mr. MCANENY. No, it is approximately the same, but it is less than 1 percent. Ironically you find that maybe one fiscal intermediary for a program happens to have a higher denial rate. It is just the opposite, slightly higher than what you are finding in maybe Garrett County. I think it is going to vary locally.

The issue is still the same though. The issue is the criteria. It is not a question of what the rate is. It is the appropriateness and the application of those criteria to situations where we are dealing with patients who are 85 and over.

Mrs. BYRON. Okay. Sister Cecilia, do you find the same thing accurate, or is yours——

Sister CECILIA. I don't have the statistics with me either, but we are finding that probably approximately 2 percent are being denied. This is only a guess. They are taking a harder look at admissions in total than at the continued stay. There are the two aspects to that program, so you have to look at both.

Mrs. BYRON. Would you know what percentage of your admissions come under this category?

Sister CECILIA. Under what category?

Mrs. BYRON. Medicare category.

Sister CECILIA. Over 40 percent of our patients admitted to the hospital are Medicare patients.

Mrs. BYRON. Forty percent?

Sister CECILIA. Correct.

Mrs. BYRON. What about yours? It is about the same?

Mr. MCANENY. Yes.

Mrs. BYRON. When you are talking about 40 percent of your patients admitted to the hospital, your denials are basically on admission or on certain types of medical procedures or on continued care?

Sister CECILIA. It is all of them. For example, patients who are admitted for surgery which they cannot have on an outpatient basis due to their physical condition would be totally denied. The

whole admission would be denied. Many times they will say the last 1 day or the last 2 days of extended care was unnecessary and deny the 1 day or 2 day or 3 day's stay. So we are seeing all of these.

Mrs. BYRON. In your written testimony, you cited several cases where admissions have been denied. In those cases, appeals were made?

Sister CECILIA. An appeal was made. It is very rare that this is ever changed in our experience. On occasion, it is, but many times, it is not.

Mrs. BYRON. The reasons for turning down the appeal were the same reasons that were cited in the original denial?

Sister CECILIA. Correct, they simply uphold the decision made initially.

Mrs. BYRON. You cited in one case that an individual needed physiotherapy. Would that not have been a prime case for rehabilitation in a nursing home?

Sister CECILIA. Correct, but we had no nursing home beds available at that point in time.

Mrs. BYRON. If I am not mistaken, I thought I heard someone testify that this community was very fortunate in the fact that they have a large number of nursing home beds. Is it just a question of at that time they were filled?

Sister CECILIA. We recently opened up a new nursing home.

Mrs. BYRON. We have some yes noddings and we have some no noddings, so I think we have a little——

Sister CECILIA. We have had a waiting list for nursing home beds for a long period of time.

Mrs. BYRON. This is because of the Medicare certification on those beds?

Sister CECILIA. They have no beds. They are filled up completely, 100-percent occupancy. Also, there is a problem on the type of care. They are able to be more selective in which patients they will admit. Skilled nursing care may be a problem for many.

Mrs. BYRON. OK.

Mr. MCANENY. Representative Byron, I think the point is that up until recently, there have been an inadequate number of nursing home beds. The ones that are there are very fine.

Mrs. BYRON. I am not questioning the care of the nursing home beds. I am just questioning the volume, the number and the needs.

Mr. BONKER. The home Medicare system breaks down if you don't have extended care facilities in place as soon as a patient becomes ambulatory so they can move from a more expensive level of care into another. There is a gap if there are not enough nursing homes or nursing home beds certified to accept Medicare patients.

Let me try to just size up what we are getting out of this hearing. Frankly we have learned things here in Allegany County that we haven't been learning back in the Nation's capital. That is not surprising.

While we did not debate the issue extensively, the congressional intent in issuing prospective payments to hospitals was to bring about greater economies. The intent was to look at the length of stay. Perhaps some hospitals who needed to fill up their beds to get to a profit margin, kept patients unnecessarily long. That may or

may not have been a case here. I think that nationally this is one of the things that prompted Congress to accept the new concept, so that we could bring about the needed economies.

I don't think our intent was to change the criteria for admission. I have always felt that the program relies heavily on the professional judgment of physicians. If a physician feels that a person needs to be an inpatient, that should be sufficient. We have to trust the integrity of the medical profession when it comes to admission. That cannot necessarily be a bureaucratic or an economic based decision.

I don't think Congress intended to change the admission criteria. I think that has come with the current administration's efforts to squeeze more savings out of the program. They felt the DRG was a good opportunity, if you will, to achieve this end.

Now, Mr. McAneny said that the basic law hasn't changed in this respect. It is a matter of interpretation. I have dealt with too many Federal programs and know that what he says is right. There is a new hard line interpretation that is probably being forced upon the agency by OMB. They try to get more savings out of social security so we can make this deficit problem look better than it is.

Based on what I hear today, which I think are legitimate complaints. We ought to take this issue back to the full committee, Beverly, and call for hearings. We will get the various Federal agencies before us and pose some pretty tough questions, such as why are they changing the criteria for admission. What statutory authority do they have to move in this direction?

Otherwise, people are going to be denied admission and in the long-term, intensive care may be far more costly. What are we saving in the long-term? We are defeating the purpose. If you have gotten nothing else across today, and I think I can speak for your Congresswoman, I think that message has come across very clearly. Maybe we could get Congressman Claude Pepper, who chairs the Health Subcommittee, to join us in hearings. We can get HCFA before us so they can answer some of these important questions.

Well, I want to thank the panel for quality testimony, and for helping the Congresswoman and myself understand more fully what you are dealing with with the changed criteria coming out of Washington. Thank you.

We have one panelist who did not testify, but does have a prepared statement for the hearing record. Hearing no objections, the statement of Mary Susan Straw will appear at this point in the record.

[The prepared statement of Mary Susan Straw follows:]

PREPARED STATEMENT OF MARY SUSAN STRAW, DIRECTOR, AREA AGENCY ON AGING, ALLEGANY COUNTY

Efforts and resources need to be channelled into expanding and refining the in-home and long term care systems serving the elderly. Two factors supporting this need are the desirability of providing sufficient quality and quantity of support services to maintain older persons in the community for as long as possible, and two, the simple matter of cost.

There is a tremendous benefit financially in providing supportive in-home and community services vs. frequent hospitalization and/or institutionalization. In-home services are cost effective until the point is reached when the total cost to keep an individual at home equals the cost of institutionalization. Development and expansion of community-based service systems for vulnerable older persons and their families is necessary.

Promoting the expansion of in-home services in sufficient quality and quantity for those older persons whose impairment level still makes in-home services a cost-effective alternative, is a sensible approach to a more cost-effective use of Medicare/Medicaid benefits. Emphasis needs to be placed on health promotion and education to emphasize the development and dissemination of educational materials for older persons.

Improving one's health through one's own actions requires well-informed individuals as well as trained professionals. Reducing the risk of disease and injury requires active participation of the individual to consistently choose a life-style that promotes health and fitness. To make these decisions, older persons need reliable information and support in making needed behavioral changes. In addition, elderly persons need improved access to preventative physical health and mental health services. Early identification of high risk older persons is important to prevent health conditions from deteriorating significantly before being brought to full medical attention.

In a recent study conducted by the State Office on Aging and outlined in The Chartbook on Aging, the reasons elderly persons give for not seeking care, 40% stated they did not seek care because they thought they would get better anyway, and 15% stated that care was too expensive. One problem related to this issue is the access problems that older persons face in reaching appropriate health services. The establishment of health assessment centers or special health clinics located in senior centers, hospitals, and community health clinics would have a major impact on providing a vehicle for bringing together a wide variety of existing resources to provide health screening, health promotion, and supplementary health services to older persons in need.

This effort would contribute to preventing diseases and injury and to increasing the early identification of health problems among the high risk elderly. In addition, dental hygiene and other dental care are important components in the nutrition, morale, and health status of older people. The success of preventative dentistry over the past twenty-five (25) years has helped change the dental needs of those approaching old age today.

Unlike the present older population which extensively uses dentures, these newer cohorts will be more likely to have most of their teeth. This will require on-going dental management, particularly preventative care related to periodontal diseases. The whole population would benefit from efforts in this area, but special attention should be directed to the home-bound and institutionalized who are now virtually ignored by the dental profession.

In conclusion, it is imperative that the Medicare/Medicaid reimbursement system be as innovative in its approach to repayment as demographics identify the changing needs of the population being served.

Now, we have one more witness. Don't leave. You may yet hear something that is new.

Kathryn Cannan is here representing the Maryland Health Systems Agency. Maybe you can give us some answers, Ms. Cannan. We are looking around for a better understanding of what is happening with these changing times in health care.

You are the director of the Health Systems Agency?

PANEL FIVE: CONSISTING OF KATHRYN CANNAN, STAFF COORDINATOR FOR IMPLEMENTATION, HEALTH SYSTEMS AGENCY OF WESTERN MARYLAND

STATEMENT OF KATHRYN CANNAN

Ms. CANNAN. No, I am not the director. I am the coordinator for implementation at that agency. The director is Kery Hummel. He is not able to be here this morning.

I have some copies of my testimony which I will hand in. I have to start out by saying that probably what is in my testimony is nothing new.

First of all, my task this morning was to synthesize everything that has been raised, bring it to a broader context and make some recommendations on behalf of the Health System Agency. The kinds of recommendations that we make are ones that induce positive changes for health care consumers.

Coming from the providers themselves who have to deal with this system on a daily basis, this morning's hearing has been a real eye-opener. I know it has been for me because as a planner I tend to deal with the system at a much more abstract level.

I am not going to spend a lot of time on my testimony because you can read it. However, when you do sit down to read it, I would like you to look over the different aspects of each county. I pull each county together as a comparison and contrast.

Basically, what I did was to take you through some geographical data county by county. I talked about population density and inches of snowfall and so forth, because I think these kinds of things really have to do with what elderly people face every day to get various kinds of care in their county.

I also talked about demographic features, things that you have already heard about, such as the structure of the population with regard to the percent of the population that is elderly. I talked about the percent of the elderly who are subscribers to Medicare, part A, and part B. I did that for each county.

I also brought in unemployment figures and the percent of the population aged 65 years and older who are below the poverty level. I think these are real important figures when you start talking about whether or not the people in the county can take care of their elderly loved ones.

I talked about some various health status figures to show which diseases people in the counties were dying from most frequently. I also did a brief description of the system in each county. I told you a little bit about the size of the hospital, and the beds per population. I also talked about the amount of the population that lives greater than 30 minutes of summer driving time from a hospital.

This is not necessarily the hospital in the county. I talked about how far they would have to go to obtain tertiary care.

I also mentioned in there the size of the Medicare population that comes through each of the hospital's doors. This is by county. I gave you a brief description of the nursing homes, the number of nursing home beds, the bed to population ratio, how many Medicaid patients they take, and so forth.

Something else I want to mention is that in all three of the counties represented here today, we have what I am sure you know is a federally designated health manpower shortage area and medically under served area. This has a great deal of impact on the ability of the elderly, in fact, everyone in the counties to obtain basic primary care services.

What I want to do after just sort of highlighting the approach that I use, is to just zip right square to the back of my testimony where I sort of pull together the common threads that are woven throughout the testimonies we have heard today. I told you a little bit about the efforts that Maryland has been making as a whole toward cost containment.

We have heard about the need for Medicare to pay for certain effective prevention measures. We heard about that from the dentists and physicians. We heard about that from those that provide home health services and hospital care and from those that provide social services for the elderly.

It is important to note that preventive measures are not limited to just the well elderly. They are appropriate for anyone whose condition has the potential for worsening. We all know our condition can worsen.

We all know the effect of prevention from our personal experience. We know that prevention may incur costs for us above what we are already paying out in medical insurance premiums and medical bills. We are willing to pay those costs because of their impact on the quality of our lives and the future outlay for after the fact medical care.

Something else we heard about this morning was the difficulty providers are experiencing in receiving Medicare reimbursement. They submit and resubmit, justify, and rejustify, only to have their claims denied. In some of the written testimony, we have had documentation of the time involved.

We heard about the need for regulatory flexibility that is responsive to an individual patient situation. We don't all fit into the rigid mold established by a diagnosis related group and its assigned length of stay. For example, we have other complications in our lives. It seems to me this was spoken to very eloquently this morning.

Perhaps we live in a county with few community based services of the type that we have heard about. Perhaps we live a long way away into the mountains. Perhaps our relatives and care givers themselves are elderly or ill. We have heard that some of our most vulnerable citizens are afraid of the very programs set up on their behalf. They are afraid to use it because it is complicated and it is incomplete in coverage. They are afraid not to use it because they might become sicker.

We have heard that Medicare reimbursements that come in late have an impact on hospital. Major policy changes in the program, burdensome paperwork on patients, and regulatory rigidity thwarts hospitals from providing the sub-acute level of care frequently needed by an elderly patient who "should be discharged from the hospital," but cannot because both home care and nursing home care are inappropriate and other community based services are unavailable.

We heard similar testimony from providers of home health services. It seems that the ability of our providers to insure availability, accessibility, continuity and quality of services are being challenged. There are certainly values traditionally held by health planners.

Finally, if we listen very carefully we can hear between the lines the voices of sick, frightened, and financially vulnerable elderly citizens who keenly feel Medicare's adverse effects. I know I can speak for them and for every one of us here, including our congressional representatives, that we all want to be situated throughout our lives so that if we become ill, neither our families nor ourselves will also become poor.

Some of us have the financial wherewithal to set this up during our time in the work force. Some of us haven't. Some of us do have the wherewithal, but have chosen not to. However we get there, there are large numbers of us who face the terrifying reality that sick equals poor.

Medicare has been a life preserver for many. I think we are in agreement in this society that Medicare is worthwhile, even if it is costly, because we know we will pay for it later if we don't have it. We will pay at a much higher cost, both in terms of dollars and human suffering.

Now, I would like to come to the last task, and that is to make some recommendations on behalf of the Health Systems Agency. They may find their way into the legislation and are designed to fix what is wrong with Medicare these days.

Here is our list, and it is real short. First, review the original legislation for its intent. Something I heard today that makes all kind of sense to me is that Medicare is an acute system. It is not set up for people with chronic needs. Maybe that is part of what is going on and what is wrong with Medicare today.

Anyway, you need to compare it with the data that indicate whether or not the program is meeting the needs of the elderly and to what degree. It is obvious from today's testimony that the program isn't working for everyone.

Secondly, act on the recommendations that the presenters have suggested here. These people are knowledgeable and pragmatic. They work with it every day. Their hearts are in the right places. Trust what they are telling you and engage them in helping you draft the legislation.

Thirdly, build into the legislation regulatory and financial incentives that will promote innovative approaches that are designed to handle the problems highlighted here. My agency has worked with the hospitals in our region to implement an approach that hasn't even been mentioned here today. This is the concept of a discreet

geriatric unit within a hospital, similar to, for example, a pediatric or obstetric unit.

Preliminary data from hospitals outside this State that have tried this approach show that elderly patients leave the hospital earlier. More importantly, they leave in better physical and mental states as a result of concentrated care appropriate to their condition and age.

The approaches that we have heard about this morning all fall under this recommendation and could be implemented very quickly in Western Maryland as pilot demonstration projects.

That pretty well sums it up. Thank you very much for this opportunity to speak. I trust that all of us here have given you some useful information.

[The prepared statement of Ms. Cannan follows:]

PREPARED STATEMENT OF KATHRYN CANNAN, STAFF COORDINATOR FOR

IMPLEMENTATION, HEALTH SYSTEMS AGENCY OF WESTERN MARYLAND

Good morning. My name is Kathryn Cannan. I work as the Staff Coordinator for Implementation at the Health Systems Agency of Western Maryland. My agency, established in June of 1976, is the public regional planning body authorized under federal law (P.L. 93-641) and Maryland law (H.B. 1536) for Maryland's four westernmost counties. We are one of five such agencies across the state along with the Maryland Health Resources Planning Commission, the final decision-maker in the state's Certificate of Need process. We are also one of about 155 Health Systems Agencies across the U.S. We conduct planning and implementation activities for most components in Western Maryland's health care system similar to the activities carried out by counties or municipalities in planning and zoning for land use.

My task this morning--to synthesize the issues raised by previous speakers, to bring a broader context to these issues, and to make recommendations as a means of inducing positive change for health care consumers--provides the perfect opportunity to demonstrate my agency's expertise. For this opportunity and your willingness to listen and on behalf of my agency's Executive Director, Kery C. Hummel, we wish to thank Representative Beverly Byron from our own Sixth District who serves on the Select Committee on Aging and Representative Don Bonker, Chair of that Committee's Subcomittee on Housing and Consumer Interests.

Before I pull together the common threads of the previous testimony, let me first take a few moments to give you a flavor for the diversity across the three neighboring counties represented here. I'll do this by highlighting some characterics pertinent to health care for rural elderly Medicare subscribers in Western Maryland. For example, I'll bring in geographic, climate, demographic, and health status information along with a brief description of what is available in the way of the primary, hospital, and nursing home care components for each county.

Furthest west is Garrett County, one of Maryland's largest at 662 square miles and also one of Maryland's most sparsely populated with 41 persons per square mile. Within its boundaries are elevations rising to 3,300 feet. In 1984, the last year for which I have data, 82 inches of snow fell on Garrett countians. This is considerably less than the 34 inches that fell on Allegany countians or the 27 that fell on Washington countians that same year, and in fact, is much less than normally falls there!

Interim population figures based on the 1980 census indicate that 12.5% of Garrett countians are elderly (that is, aged 65 years and over), which makes Garrett similar in this regard to Washington County at 12.8%. Of these individuals in Garrett County, 89.4% subscribed to Medicare Part A and B or both on July 1, 1984, according to HCFA. This figure, by the way is lower than the national average of 95-97% and lower than both Allegany County at 99.7% and Washington County at 95.5%.

Unemployment in Garrett County averaged 11.3% during 1985, while the State experienced only 4.6%. A notable 25% of Garrett Countians aged 65 and older were below the poverty line according to the 1980 census. Unemployment rates and figures indicating the percent of elderly below the poverty level are important figures in terms of assessing whether families are able financially to care for their elderly loved one, and conversely, the need for adjunctive services. There is no public bus transportation in Garrett County, and 10% of occupied households have no vehicle available, again according to 1980 census data.

Let's look at how Garrett County elderly compare with their cohorts living in the other two Western Maryland counties and the state for death rates. In 1983, the death rates for elderly Garrett countians were higher for heart disease, cerebral vascular accidents, and diabetes compared to their cohorts in the two other Western Maryland counties and the state as a whole.

Located in Oakland, the county seat, are the only hospital and the county health department from which home health services are delivered. The 76 general acute care hospital beds translate into a bed to population ratio of 2.8 beds per 1,000 people. This is the lowest ratio among the three counties as you will hear. A study recently completed by my agency shows that about 1400 Garrett countians (2.4% of the total population) live more than 30 minutes of summer driving time to an acute care general hospital somewhere (i.e., neighboring West Virginia, Pennsylvania, and Maryland counties), though not necessarily Garrett Memorial Hospital in Oakland. In terms of a source of tertiary care, patients and their families would need to travel from Oakland 50 rugged miles to Cumberland, 40 to Morgantown, West Virginia, 100 to Pittsburgh, Pennsylvania, or 188 to Baltimore, Maryland.

Data from Maryland's Health Services Cost Review Commission indicate for the fiscal year ending June 30, 1985, Medicare subscribers accounted for 38% of Garrett Memorial Hospital's caseload and 56% of its revenues.

There are 336 nursing home beds within the county's borders, amounting to 98 beds per 1000 elderly. The statewide planning methodology projecting future need for nursing home beds which my agency helped to construct shows no need for additional beds in Garrett County by 1990. Based on the 1984 Nursing Home Survey conducted by the Maryland Health Resources Planning Commission, the nursing homes in Garrett County (and in the other two Western Maryland counties, for that matter) average above 98% occupancy per year and over 65% Medicaid patients on a given day.

All of Garrett County has been designated by the federal government as a Medically Underserved Area (MUA). This designation means that all 26,498 citizens of Garrett County have degrees of difficulty accessing primary care services for a variety of reasons spelled out in the definitions MUA, including the ratio of primary care physicians to population, infant mortality rate, percentage of the population aged 65 and older, and percentage of the population with family income below the poverty level.

I hope I have succeeded in painting a vivid picture of Garrett County against which you can contrast the other two.

Allegany County is similar in size to Washington County, about 440 square miles. The population density approximates 200 persons per square mile--in Washington County, it's closer to 250--so both are crowded by Garrett County standards! Elevations in Allegany reach 2,700 feet at the highest point and only 800 feet in Washington County.

With regard to demographics, Allegany County stands in stark relief against the other two with almost 17% of its population aged 65 and older. You will recall that this figure is about 12.5% in both Garrett and Washington counties.

Although larger percentages of occupied households in which no vehicle is available occur in Allegany and Washington counties compared to Garrett, there is public bus transportation in both.

Unemployment in Allegany County averaged 9.1% during 1985, compared with 4.6% throughout the state. According to the 1980 census, about 14% of persons aged 65 and older were below the poverty line.

In 1983, Allegany County elderly experienced higher death rates due to chronic obstructive pulmonary disease, pneumonia, and influenza compared with the elderly living in the other two Western Maryland counties and the state.

Within the county are three general acute care hospitals, two in Cumberland and one in Frostburg 19 minutes away into the mountains. Also located near Cumberland is the Finan Center, a state-run psychiatric hospital for adolescents and adults. The beds within the three general acute care hospitals total 549. I'll mention here that this figure represents a drop of 9 beds from a year ago, consistent with the Hospital Capacity Plan, one of Maryland's major cost containment efforts to rid the state's acute care hospital system of approximately 5,000 (one-third of the total) hospital beds calculated to be in excess supply by 1988. Acute care general hospital beds in Allegany County are to

total between 350 and 375 by 1988, so further reductions are slated in the near future. In fact, Frostburg Community Hospital recently submitted a Letter of Intent to the Maryland Health Resources Planning Commission which proposes to convert some its 50 hospital beds to comprehensive (long term) care services.

As they stand, the beds-to-population ratio in Allegany County approximates 7 per 1000 citizens (more than twice that of Garrett County). 338 people (0.4% of the county's population) live more than 30 minutes of summer driving time from an acute care general hospital. Those requiring certain types of tertiary care must travel from Cumberland the 80 miles to Morgantown, 100 to Pittsburg, or 130 to Baltimore or Washington, D.C..

According to Cost Review Commission data, Medicare subscribers accounted for 40% of the cases and 54% of the revenues for all three hospitals considered together for the fiscal year ending June 30, 1985.

There are 683 nursing home beds operating in Allegany County and another 120 scheduled to come on line soon. Considered together, they bring Allegany County's ratio to 53 beds per 1000 elderly. The State Health Plan calls for an additional 122 beds by 1990.

Allegany County is the next in this west-to-east scan that has a federally-designated Medically Underserved Area (MUA) within its borders. In addition, it has a Health Manpower Shortage Area (HMSA), another federal designation which singles out for support in the development and operation of primary care clinics areas with scarce or non-existant health services. Thus, the 67% people living in the one election district with these designations have difficulty obtaining the services of a primary care physician for the reasons I mentioned when discussing Garrett County.

Let's move east now to Washington County. You already know about its size, population density, elevation, snowfall, percent of the population that is elderly, percentage of elderly on Medicare, occupancy and Medicaid participation in its nursing homes, and the fact that it has public bus transportation system.

For comparison purposes, you also need to know that unemployment ran at 7.3% during 1985. Although this was the lowest rate among the three Western Maryland counties, it was still well above the state's rate of 4.6%. Of persons 65 years and older, about 16% were below the poverty line in 1979.

Washington County elderly have the distinction in this scenario of having death rates lower than their counterparts living in the other two Western Maryland counties or in the state for seven leading causes under consideration here.

Hagerstown, the county seat, is the location for the county's only acute care general hospital, a 415 bed facility which brings the bed-to-population ratio to 3.6 per 1000 citizens. This hospital, like those in Allegany County, is experiencing excess capacity and is in the process of downsizing to 317 beds by 1988 under the Hospital Capacity Plan I mentioned earlier. In fact, it has submitted a Letter of Intent to the Maryland Health Resources Planning Commission proposing to convert 40-50 of its existing medical/surgical beds to comprehensive rehabilitation, acute psychiatric, and long term care beds consistent with projections of future need in the State Health Plan. Also located in Washington County are Brooklane, a private psychiatric hospital and the Western Maryland Center, a state-run chronic rehabilitation hospital.

Unlike the situation in the other two counties, no one in Washington County lives more than 30 minutes of summer driving time away from from a general hospital, though not necessarily Washington County Hospital in Hagerstown. Patients seeking tertiary levels of care must travel from Hagerstown about 75 miles to either Baltimore or Washington, D.C..

Washington County Hospital, just like those in Allegany and Garrett Counties, depends heavily on the Medicare program. During the fiscal year ending June 30, 1985, 30% of its caseload and 46% of its revenues were generated by Medicare subscribers.

There are 1092 nursing home beds operating in Washington County and another 50 scheduled to open in the near future. Considered together, they amount to a bed-to-population ratio of 78 per 1000

elderly. The State Health Plan projects the need for an additional 92 beds by 1990.

I mentioned earlier that all of Garrett County is a Medically Underserved Area and that one election district within Allegany County is designated as both Health Manpower Shortage and Medically Underserved Areas. By contrast, Washington County has eight elections districts with a 1980 population approximating 18,600 designated as both a HMSA and MUA.

Another piece to this Western Maryland health care scenario is the highly developed emergency medical system, nationally known for its excellence, from which the elderly in all three counties benefit.

I wish that today I could quantify for you those community-based services, both existing and needed, considered in Maryland to be crucial pieces in the continuum for our adult disabled citizens. Actually, we're only a few months away from being able to do just this, thanks to a collaborative planning effort on the parts of the Health Resources Planning Commission, the Office on Aging, the Department of Human Resources, the Department of Health and Mental Hygiene, and others at the state level as well as the Health Systems Agencies and others at local levels. In place will be a method to project an individual county's future need for assisted housing, a wide range of in-home services from skilled to chore and meals, day programs--both medical and vocational, transportation, case management, respite, and hospice care. The projections will be based on detailed aspects of a county's population.

Maryland is a trailblazer in this effort. We're optimistic about its potential to hasten the systematic development of community-based alternatives to institutions and to give guidance to the state legislature, county government, and the Department of Health and Mental Hygiene in making budgetary decisions about various programs. The effort is consistent with the pledge made by Adele Wilzack, Secretary of the Department of Health and Mental Hygiene to participants attending the 1985 annual meeting of the Maryland Coalition of Long-Term Health Care Providers to use government in the creative roles available to it as a means of insuring "financial and geographic access to care of the highest quality possible, given in the least restricted, most independent setting appropriate for each individual."

Let me interject here that we are experiencing an expansion in the availability of assisted housing alternatives for elderly citizens in all three counties. It is moving ahead in spite of the somewhat slow-moving planning process I've just described. This is happening largely, I think, because people recognize the need and because there are enabling low interest loans for property renovations as well as rent and care subsidies for low-income, frail elderly through various state government-sponsored programs. My agency has been very active in providing technical assistance to developers in all three counties.

It is no accident, by the way, that the commitment to develop and expand community-based services for the elderly comes at a time when Certificate of Need is keeping tight control on both hospital and nursing home bed supplies under the provisions of the recently-adopted Hospital Capacity and the Institutional Long-Term Care Plans. All of these measures, of course, are designed to assist Maryland in retaining the Medicaid/Medicare waiver so that all our citizens can obtain high quality care, regardless of their ability to pay.

I hope I've been successful in depicting the kinds of things an elderly Western Maryland resident faces when it comes to obtaining needed health care, depending on the county in which she or he lives. I hope, too, I've given you a glimpse of the directions Maryland is taking in the matter of health care for our elderly.

I want to move on now to pull together the common threads that are woven through the testimony, regardless of the county represented.

We heard about the need for Medicare to pay for certain effective prevention measures. We heard about that from the dentists and physicians, from those that provide home health and hospital

care, and from those that provide social services for the elderly. It is important to note that these preventive measures are not limited to the well elderly. They're appropriate for anyone whose condition has the potential for worsening, regardless of where he or she is on the wellness-to-illness continuum. We all know the effect of prevention from our personal experience. We know that prevention may incur costs for us above what we are already paying out in medical insurance premiums or medical bills. We are willing to pay those costs, however, because of their impact on the quality of our lives and future outlays for after-the-fact medical care. It has to do with getting the largest benefit for our dollar.

Something else we heard about is the difficulties providers are experiencing in receiving Medicare reimbursement. They submit and re-submit, justify and re-justify, only to have the claim denied. We even had the time involved for this process quantified by one presenter.

We heard about the need for regulatory flexibility that is responsive to an individual patient's situation. We don't all fit into the rigid mold established by a DRG and its assigned length of stay, for example, because we have other complications in our lives. Perhaps we live in a county with few community-based services of the type I mentioned, or maybe we live a long distance into the mountains. Perhaps our relatives and care givers themselves are elderly or ill.

We heard that some of our most vulnerable citizens are afraid of the very program set up on their behalf. They are afraid to use it because it is complicated and incomplete in its coverage, but they are afraid <u>not</u> to use it lest they become sicker.

We have heard that hospitals are impacted by Medicare reimbursements that come in late, by major policy changes in the program, by burdensome paperwork on patients, and by regulatory rigidity that thwarts them from providing the sub-acute level of care frequently needed by an elderly patient who "should" be discharged from the hospital but for whom both home care and nursing home care are inappropriate and for whom other community-based services are unavailable. We heard similar testimony from providers of home health services. It seems that the ability of providers to ensure availability, accessibility, continuity, and quality of services (the values we traditionally have held) is being challenged.

Finally, if we listen very carefully, we can hear between the lines the voices of sick, frightened, financially vulnerable elderly citizens who keenly feel Medicare's adverse effects. I know I speak for them and for every one of us here, including you, our Congressional Representatives, that we all want to be situated throughout our lives so that if we become ill, we and our families won't also become poor as a result. Some of us have the financial wherewithall to set this up during our years in the work force; some of us don't. Some of us do, but choose not to. However we get there, large numbers of us face the terrifying reality that sick equals poor. Medicare has been a life preserver for many. I think we are in agreement in this society that Medicare is worthwhile, if costly, because we know we'll pay later for the lack of it at much higher cost, both in term of dollars and human suffering.

Now I come to my last task--that is, to make recommedations on behalf of the Health Systmes Agency of Western Maryland that may find their way into legislation designed to fix what's wrong with Medicare these days. Here is our list:

1. Review the original legislation for its intent. Compare it with data that indicate whether the program is meeting the needs of the elderly and to what degree. It seems clear from today's testimony that the program is not working for everyone. There are ways of addressing the problems mentioned today.

2. Act on the recommendations that the presenters have suggested. These are knowledgeable, pragmatic people whose hearts are in the right place and who deal with these problems on a daily basis. Trust what they are telling you and engage them in helping you draft the legislation.

3. Build into new legislation regulatory and financial incentives that will promote innovative approaches designed to handle the problems highlighted here. My agency has worked with hospitals in our region to implement an approach not mentioned today--that is, a discrete geriatric unit within a hospital, similar in concept to a pediatric or obstetric unit within a hospital. Preliminary data from hospitals outside this state that have tried this approach show that elderly patients leave the hospital earlier, but more importantly, leave in better physical and mental states as a result of the concentrated care they receive appropriate to their condition and age.

   The approaches we have heard about this morning--wellness and prevention, swing beds, extended care beds, assessment units, non-medical community-based services--all fall under this recommendation and could be implemented quickly in Western Maryland as pilot demonstration projects.

   Many of these approaches have surfaced in studies and Congressional hearings conducted in recent times, including some held by the House Select Committee on Aging. Perhaps most notable is information reported last summer from a national study to examine the effects of DRGs on community care systems for the elderly. It was conducted by the National Association of Area Agencies on Aging and the Long Term Care Gerontology Center, Dallas, Texas. It noted the major increases in the delivery of community-based services, the demand hospitals are placing on Area Agencies to coordinate community services for the elderly and their family caregivers, and that enhanced family support services and additional community resources are more important elements to avoiding hospital readmission that longer initial stays.

Thank you again for this opportunity to speak. I trust that all of us here have given you useful information. I will be glad to answer any questions you have.

Mr. BONKER. Thank you, Ms. Cannan. That was really an excellent summary of what has transpired here this morning. Mrs. Byron, do you have any questions?

Mrs. BYRON. The hour is late and I want to thank those that are here because you have been extremely patient. We have gained a great deal of insight.

You obviously like statistics because you included a lot of them in your statement. Let me ask you what is the occupancy rate for the three counties? Are they about equal?

Ms. CANNAN. Are you talking about nursing homes or hospitals?

Mrs. BYRON. I am talking about hospitals.

Ms. CANNAN. I don't have those figures with me today.

Mrs. BYRON. Nursing homes?

Ms. CANNAN. Nursing homes are very similar. They are all well above 95 percent. In fact, they are more like 98–99 percent. That is based on the 1984 nursing home survey that was done in Maryland.

Mrs. BYRON. With that occupancy rate on nursing homes, obviously we need more nursing homes. Can you be a little specific and give us some target dates on the number of beds that we need or should be available. We could start looking down the road to see where we should go with nursing homes and whether they should be acute care or long-term care? I would assume we have a shortfall in long-term care.

Ms. CANNAN. Yes. Let me just refer to my testimony here. You are right. I do like numbers, but that doesn't necessarily mean that I remember all of them.

In Allegany County, as Sister Cecelia already mentioned, we have an additional 120 nursing home beds about to come on line. Right now we have 683 in this county and we are expecting another additional 122 by the year 1990. In other words, that is what is projected in the State health plan.

The reason I went directly to Allegany County first is because they have a bed need as projected in the State health plan for Garrett County. The occupancy rate is very high in Garrett County. This is a situation where they have a lot of clients migrating in from both out of State, and particularly other Maryland counties. The reason they are migrating from other Maryland counties is because the beds aren't there. We are hoping to alleviate some of this maldistribution.

In Washington County, similar projections then are for an additional 92 beds by 1990.

Mrs. BYRON. 92 beds?

Ms. CANNAN. Right now they have 1,092, with an additional 50 scheduled to open very quickly here. Something that I should throw in here verbally, although it is in my testimony, is that Maryland is in very much of a cost containment mode right now with regard to excess hospital capacity. They are trying to reduce the number of excess hospital beds. One of the alternatives being suggested for Western Maryland in particular, and I think probably throughout the State, is that the hospitals may want to get into the business of long-term care at some level. We are particularly looking at extended care, which I think is another name for SNF, skilled nursing home facility, in a hospital.

Mrs. BYRON. A question that has not been mentioned at all today—and yet I have seen consistently come to me in our office—is, what do you do with an individual with the long-term prognosis of Alzheimer disease? That is a whole new area that I think is just beginning to be understood. Looking toward the future in those cases, they are not really admissible in a hospital facility because they are chronically ill individuals. Yet they have just as many problems, and in some cases, more.

Ms. CANNAN. Sometimes those people do very well in sort of a traditional ordinary nursing home. True, they do present their own set of problems.

Mrs. BYRON. I think when we are talking about the new guidelines and the change in implementing those guidelines, we have to make sure that we keep the flexibility there. We have to really give the physician the tools he needs to work. The guidelines are one thing, but to take the flexibility and the decision out of the local physician on the scene, I think is certainly the wrong message that Congress never intended to send.

Mr. BONKER. Let me follow with a few questions about nursing homes.

When you say there is a shortage, is it overall nursing home beds or nursing homes that are certified to accept Medicare patients?

Ms. CANNAN. Overall beds.

Mr. BONKER. Just overall?

Ms. CANNAN. Yes.

Mr. BONKER. Well, it seems to me with this new prospective payment system and a real incentive on hospitals to move patients quickly through, invariably they are going to end up in nursing homes to further their recovery. There ought to be a real demand, if you will, for nursing home beds if this whole new program is going to be realized. If hospitals have to get the patients out, they can't just get them out the door. They have got to get them into a facility that is properly equipped to further the recovery.

Why isn't an agency doing a study on the potential need for new nursing home beds in this area? It seems to me if there is a demand, there is somebody in the private sector to meet that demand.

Ms. CANNAN. I agree with you. The agencies that comprise the health planning network in Maryland are looking at that very issue. I belong to one of them, the Health Systems Agency of Western Maryland. There are four others in Maryland. Our four overall umbrella agencies are the Health Resources Planning Commission.

Right now this is something a lot of people are not very happy about. The type of care that you are describing as being intermediate care is when you are ready to leave the hospital, but are not really ready to go home. You don't necessarily belong in a nursing home which has long-term care.

The type of care you are talking about and nursing home care are lumped under one definition and lumped under one bed need. As I said, a lot of people aren't very happy about that. The health planning network, in fact, is addressing this. We are doing a separate study. We are loathe to move forward in planning unless we have good data and documentation. We are going about trying to get that kind of documentation.

What has come out today I think is very helpful to that whole effort.

Mr. BONKER. Let me ask you, is the reimbursement rate for Medicare sufficient? Are most of the nursing homes in rural Maryland certified to accept Medicare patients?

Ms. CANNAN. Let's put it this way. I had not heard of that being an issue. I deal with four Western Maryland counties. To my knowledge, all the nursing homes are certified.

Mr. BONKER. In my area, in the rural area of Southwest Washington, we have a lot of nice nursing homes, but they don't accept Medicare patients. They don't accept them because they don't want the additional expense of skilled nursing care and all the other requirements that come with Medicare reimbursement.

So the nursing beds are there, but they just won't take Medicare patients.

Ms. CANNAN. In Maryland, at least under Medicaid reimbursement, the emphasis is very much on what they call the heavy and heavy special care. Medicaid reimbursement is divided down into several categories, the lowest being light care, then intermediate or moderate and then heavy and heavy special.

The nursing homes do best in terms of financial reimbursement by taking the heavy and heavy special care. To a degree they overlap with skilled nursing.

Mr. BONKER. You are saying that the Medicaid requirements in some instances are as high as Medicare requirements?

Ms. CANNAN. Yes.

Mr. BONKER. So that is really not a problem in this State.

Ms. CANNAN. I don't think it is, yes.

Mr. BONKER. Maybe in some instances Medicaid would require around the clock nursing care. But in my area it is a real problem, because the profit incentive, if you will, is much greater on Medicaid, even though Medicaid pays much less than Medicare reimbursement.

Do you know what the reimbursement rates are here?

Ms. CANNAN. I believe for special and heavy special, it is $55 to $65. We may have some people here in the audience that can speak to this better than I.

Mr. BONKER. Versus $62 for Medicare. So it is about the same?

Ms. CANNAN. Yes.

Mr. BONKER. This is a very critical issue. We have had some excellent testimony today. Congresswoman Byron is right on top of what we feel is a number one issue involving the senior citizens. I think with this information we can go back to Washington, DC, and make available the testimony of today's hearing to the chairman of the full committee, Mr. Roybal. Perhaps we can involve Mr. Pepper. They can conduct a hearing back in DC, which will involve the people who administer the program. They will be able to see why they are changing the criteria and making it more difficult for people to get inpatient care.

I want to thank everybody here for their patience and their attention. I am sure that this area will make its mark felt on the Nation's capital when we take up this issue later.

Beverly, do you have a closing statement?

Mrs. BYRON. Let me just say that the most dramatic things I have heard today are the case-by-case examples that have been mentioned. When you look at an individual case instead of larger numbers, you can see the 81 year old gentleman or 90 year old woman. You see the agony that goes on with the family as well as the agony of a physician that is put into a bind to administer medical care with those kind of criteria.

This is a very important fact. I know, since constituents come in to me with problems concerning their parents. I have had wives come in to me with problems about their husbands, who are senior citizens. I have had physicians come in to me with the problems of trying to give good quality care and appease hospital administrators.

It really isn't a case where the physician is battling the hospital. The hospital is battling the constituent. Somehow we have gotten so stringent with the basic criteria of the guidelines that we cannot interpret them for the best care of our senior citizens.

As in any field hearing, the members would love to tell everybody that they came in and handled the whole thing by themselves, but we didn't. There really is a tremendous amount of staff work that goes into setting up a field hearing. Staff work is needed to get the quality of witnesses and the diversity of testimony necessary for us to understand what the problems are.

Without the help of Sue Davis of the area health education center here in Cumberland, we would not have had such an outstanding hearing.

I have to take 2 seconds for my own staff. Each of us have a diverse staff in legislative fields. I have had Jackie Sullivan doing my staff work for the last 5 years. This is her last hearing. She is going out to New Hampshire next week and practice law as a prosecuting attorney. When Jackie gets into court in a couple of weeks I am sure she is going to be wishing that she might be back here at an aging hearing in Cumberland with a delightful constituency. I want to thank her for her work.

Mr. BONKER. With that, the hearing stands adjourned.

[Whereupon, at 2 p.m. the hearing was adjourned.]

APPENDIX

COMPENDIUM OF CASES

QUALITY OF CARE PROBLEMS GENERATED BY MEDICARE POLICY

(Submitted for the record by Wayne C. Spiggle, M.D.)

M.B.-AGE 65- SEVERE SHOULDER PAIN DUE TO METASTATIC CANCER OF BREAST, RESISTANT TO OUT-PATIENT THERAPY. ADM. DENIED.

W.C.-AGE 60- SEVERE BACK PAIN RESISTANT TO OUT-PATIENT THERAPY. DEVELOPED RECTAL BLEEDING. LESION DISCOVERED ON COLON. ADM. DENIED (CALLED "DIAGNOSTIC ADM.").

E.M.-AGE 82- ANEMIA & WGT. LOSS. DID NOT MEET CRITERIA FOR ADM.. SO COLON X-RAY DONE AS OUT-PATIENT (A VERY DIFFICULT TASK FOR ANY ELDERLY PATIENT). COLON LESION FOUND. ADM. FOR MEDICAL STABILIZATION TO CONSIDER SURGERY. ADM. DENIED.

N.L.-AGE 67- CHRONIC OBSTRUCTIVE LUNG DISEASE AND INTRACTABLE HEART FAILURE. ADM. FOR 11 DAYS. THE LAST 5 DAYS DENIED ON RETROSPECTIVE ANALYSIS. APPEAL WAS TIME CONSUMING AND UNSUCCESSFUL. PATIENT DIED.

I.S.-AGE 53- PRESENTED WITH FLU-LIKE ILLNESS & APPEARED VERY ILL. INSURANCE CARRIER HAS ADOPTED MEDICARE CRITERIA FOR ADM. AND PATIENT DID NOT FIT. RELEASED FROM EMERGENCY ROOM TO BE FOLLOWED IN DOCTOR'S OFFICE. BROUGHT BACK TO E.R. 24 HRS. LATER IN FULL CARDIAC ARREST. PATIENT DIED. FAMILY'S ANGRY COMMENT: "DO YOU HAVE TO BE DEAD TO BE ADMITTED TO A HOSPITAL?

M.M.-AGE 66- ADM. WITH NEW ONSET GRAND MAL SEIZURE. ADM DENIED RETROSPECTIFULLY DESPITE FACT PATIENT SUFFERED A 2ND SEIZURE WHILE IN THE HOSPITAL. LONG INVOLVED APPEAL PROCESS FOLLOWED AND WAS EVENTUALLY SUCCESSFUL. THE EMOTIONAL TRAUMA ON THE PATIENT REMAINS UNADDRESSED.

I.E.-AGE 82- HAD R CARPAL TUNNEL SYNDROME DEPRIVING HER OF STRENGTH IN THE WRIST. BECAUSE OF L KNEE PAIN AND ARTHRITIS NEEDED USE OF R HAND IN ORDER TO WALK WITH A CANE. PATIENT ADM. FOR SURGERY BECAUSE SHE WAS UNABLE TO WALK SAFELY AND NO FAMILY WAS AVAILABLE. ADM. DENIED BECAUSE CARPAL TUNNEL RELEASE IS AN OUT PATIENT PROCEDUE ONLY . THE ALTERNATIVE OF HOSPITALIZATION WAS TO EXPOSE THE PATIENT TO A HIGH RISK OF FALLING AND SUFFERING A BROKEN HIP.

C.B.-AGE 74- HAD NON-DISPLACED FRACTURE OF TIBIA AND FIBULA SECONDARY TO SEVERE OSTEOPOROSIS. PT. HAD NEVER USED CRUTCHES OR WALKER BEFORE. DOCTOR ADMITTED PT. FOR OBSERVATION UNTIL PHYSICAL THERAPISTS TRAINED HER TO USE WALKER TO MAKE SURE THAT PT. WOULD NOT FALL AND BREAK ANOTHER OF HER BRITTLE BONES. ADM. DENIED. BECAUSE NON-DISPLACED TIBEAL FRACTURES ARE SUPPOSED TO BE TREATED AS OUT-PATIENTS.

COMPENDIUM OF CASES DR. SPIGGLE'S TESTIMONY 6/9/86

J.A.-AGE 69- HAS SEVERE ALZHEIMER'S DISEASE AND RECENT ONSET SEIZURES. REQUIRED MULTIPLE DENTAL EXTRACTIONS AND PERIDONTAL SURGERY. DENTAL SURGEON AND DOCTOR AGREED THAT UNSTABLE NEEDS OF PATIENT REQUIRED HOSPITALIZATION. MULTIPLE APPEALS TO PRO REFUSED ON GROUNDS THAT CRITERIA FOR HOSPITALIZATION NOT MET. PT. ADM. ON GROUNDS THAT IT WOULD BE UNETHICAL TO WITH HOLD HOSPITAL CARE IN THIS CLINICAL SITUATION. DOCTORS AND FAMILY WARNED THAT IF THERE WERE NO POST OPERATIVE COMPLICATIONS RETROSPECTIVE DENIAL IS CERTAIN.

ELDERLY PT. WITH CHRONIC LUNG DISEASE IN OBVIOUS CLINICAL NEED FOR HOME OXYGEN TREATMENT. DENIED BECAUSE THE OXYGEN CONTENT OF THE BLOOD WAS "THREE POINTS TOO HIGH" TO FIT MEDICARE CRITERIA.

SIMILAR PT. DENIED OXYGEN TREATMENT DESPITE THE NEED TO HAVE IT TO TOLERATE EVEN MODEST ACTIVITY IN HER OWN HOME, ALL BECAUSE MEDICARE CRITERIA ARE BASED ON ARBITRARY NUMBERS.

PT.-70 TO 75 Y.O.- PRESENTED WITH SEVERE SHORTNESS OF BREATH AND CONGESTIVE HEART FAILURE REFUSED TO BE ADMITTED DUE TO "STORIES ABOUT MEDICARE". ' STATED SHE COULD NOT PAY BILL & WOULD RATHER LEAVE WHAT LITTLE SHE HAD TO HELP ILL SISTER. BECAME MUCH WORSE AT HOME & NEARLY DIED BEFORE COMING TO HOSPITAL. HOSPITAL STAY WAS SIGNIFICANTLY LONGER THAN WHAT WOULD HAVE PREVIOUSLY NECESSARY.

PT.-80 PLUS- FELL AND SUSTAINED INJURY TO HIP, BACK & CHEST. DENIED ADM., BECAUSE NO FRACTURES WERE PROVEN ON X-RAY. PT. UNABLE TO WALK DUE TO THE FALL.

G.V.-AGE 85- FROM PETERSBURG, W.VA. (60 MILES AWAY) REFERRED WITH BACK PAIN & DIFFICULTY WALKING. BECAUSE THERE WAS A HIGH SUSPICIAN OF SPINAL TUBERCULOSIS A VERTEBRAL BIOPSY WAS NECESSARY TO ESTABLISH A PROPER DIAGNOSIS. HOSPITALIZATION FOR THIS PROCEDURE DENIED BECAUSE PATIENT DID NOT FIT MEDICARE CRITERIA; AGE, DISTANCE, AND POTENTIAL COMPLICATIONS OF PROCEDURE NOT ACCEPTED FACTORS. MUCH PHYSICIAN TIME REQUIRED TO GAIN PERMISSION TO HOSPITALIZE PT. FOR THIS POTENTIALLY DANGEROUS PROCEDURE.

A.R.-AGE 62- WITH METASTATIC LUNG CARCINOMA ADMITTED FOR ACUTE RESPIRATORY FAILURE. UTILIZATION REVIEW QUESTIONED HOSPITALIZATION BY THE 3RD OR 4TH DAY OF ADMISSION AND AN ARGUMENT ENSUED SINCE HE WAS ESSENTIALLY ADMITTED FOR TERMINAL CARE. THE PT. HAD A GREAT DEAL OF ANXIETY THROUGHOUT HIS HOSPITALIZATION OVER THE THREAT OF "BEING CUT OFF". HE FELT THAT HE WAS TOO WEAK AND ILL TO GO HOME AND THE HOSPICE SETTING WAS NOT AVAILABLE ATH THE TIME. HE WAS DESPERATE TO STAY IN THE HOSPITAL, SO HE ACCEPTED PARENTERAL TREATMENTS WHICH FIT THE CRITERIA, DESPITE THE FACT THAT HE WOULD PROBABLY BEEN MORE APPROPRIATELY TREATED WITH SYMPTOMATIC CONTROL ALONE. HE ULTIMATELY DIED IN THE HOSPITAL SETTING, BUT ONLY AFTER EXPERIENCING SIGNIFICANT ANXIETY.

E.T.-AGE 72- HAD BACK PAIN SUBSEQUENTLY FOUND TO HAVE BOTH THE

VERTEBRAL COMPRESSION FRACTURE AND AN ABDOMINAL AORTIC ANEURYSM. HE ULTIMATELY DID NOT "MEET THE CRITERIA" BECAUSE NO ACTIVE MEDICAL INTERVENTION WAS UNDERTAKEN. HOWEVER, THE UTILIZATION REVIEW IGNORED TH FACT THAT THE PT., WHO HAD NOT BEEN PREVIOUSLY ILL, NEEDED SOME TIME TO CONSIDER THE OPTIONS AND DECIDE WHETHER HE WAS GOING TO HAVE MAJOR SURGERY TO REPAIR THE ABDOMINAL AORTIC ANEURYSM. APPARENTLY THEY EXPECTED AN INSTANTANEOUS DECISION AND WHEN HE DECIDED AGAINST THE SURGERY, THE ADMISSION WAS DENIED BECAUSE NOTHING WAS BEING DONE THAT MET MEDICARE CRITERIA.

M.M.-AGE 81- HAD SEVERE BACK PAIN DUE TO A VERTEBRAL COMPRESSION FRACTURE. AGAIN, THERE WAS A GREAT DEAL OF ANXIETY OVER HER ADMISSION BECAUSE THERE WAS NO TREATMENT THAT WAS NECESSARY OTHER THAN ANALGESICS, BUT SHE FELT THAT SHE COULD NOT GO HOME UNTIL SHE WAS BETTER ABLE TO AMBULATE AND RESUME CARING FOR HERSELF.

B.S.-AGE 77- HAS CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND WAS UNDER HOSPITAL TREATMENT FOR COMPLICATIONS OF THAT PROCESS. ALTHOUGH SHE COMPLAINED OF FEELING WEAK AND "NOT HERSELF AND NOT READY TO GO HOME", SHE ULTIMATELY WAS PRESSURED INTO GOING HOME BECAUSE SHE DID NOT MEET MEDICARE CRITERIA FOR CONTINUED STAY IN THE HOSPITAL. WITHIN FIVE DAYS SHE HAD TO BE READMITTED WITH HIGH FEVER AND MORBID ILLNESS. SHE WAS SUFFERING FROM PYELONEPHRITIS. HER DOCTOR FEELS THAT THE DIAGNOSIS WOULD HAVE BEEN APPARENT MUCH SOONER IF HER DISCHARGE HAD NOT BEEN MANDATED BY MEDICARE.

G.E.-AGE 80- DISCH. FROM HOSP. WHEN CRITERIA NOT MET. DIED TWO DAYS LATER.

J.J.-AGE 60- DISCH. FROM HOSP.- CRITERIA PBS.- CANCER OF COLON. AORTIC STENOSIS, CONGESTIVE HEART FAILURE, CHRONIC SEIZURE DISORDER. DIED IN E.R.

M.M.-AGE 72- ABDOMINAL AND BACK PAIN DUE TO CANCER. RECIEVED NOTIFICATION OF POSSIBLE DENIAL WHILE STILL IN THE ADM. OFFICE. CONTINUED APPREHENSION OVER REVIEW DYNAMICS ACTUALLY CONTRIBUTED TO HER DEATH.

C.F.-AGE 80+- DEMENTIA AND CEREBROVASCULAR ACCIDENT. HOSP. DENIED WHILE AWAITING N.H. PLACEMENT. CAUSED PT. & FAMILY GREAT DISTRESS PENDING PLACEMENT.

A.W.-AGE 72- SEVERE BACK PAIN DUE TO COLLAPSED VERTEBRAE AND OSTEOPOROSIS. HOSP. FOR PAIN CONTROL AND INTENSIVE PHYSICAL THERAPY. DENIED.

J.T.-AGE 77- ABD. PAIN. SEVERE. ADM. DENIED - TESTS ORDERED ON OUT PT. LIST. DIED OF CARCINOMA OF THE PANCREAS.

O.H.-AGE 74- ABD. MASS NEEDED LIVER BIOPSY & AT RISK FOR POST PROCEDURE BLEEDING COMPLICATIONS. ADM. DENIED.

COMPENDIUM OF CASES DR. SPIGGLE'S TESTIMONY 6/9/86

M.M.-AGE 75- INCAPABLE OF SELF CARE. TRANSFERED TO FINAN CENTER - NOT ACCEPTED - BROUGHT BACK TO HOSPITAL. ADM. DENIED.

J.M.-AGE 65- ADM. TWICE IN 7 DAYS WITH UNCONTROLLED DIABETES - BOTH ADM. DENIED.

E.M.-AGE 75- LIVES ALONE & WHEELCHAIR BOUND DENIED ADM. FOR POSSIBLE COLON CANCER.

M.B.-AGE 78- INCREASED CONFUSION AND NO CARETAKER. ADM. FOR N.H. PLACEMENT. DENIED.

C.J.-AGE 72- LIVES IN UPPER TRACT, W.VA. (60+ MILES AWAY). NEEDED STAGING OF LUNG CANCER. HAD TO MAKE 5 TRIPS OVER TWO WEEKS FOR OUT-PT. EVALUATION. WAS WEAKENED BY THE PROCESS. COULD HAVE BEEN DONE IN A THREE DAY HOSPITALIZATION WITH MUCH LESS TRAUMA TO THE PT.

L.A.-AGE 70- LIVES IN PETERSBURG W.VA.(60 MILES). COUGHING BLOOD DUE TO CANCER OF THE LUNG. NEEDED TO BE HOSPITALIZED FOR TREATMENT. WAS EXPOSED TO POTENTIAL BLEEDING CATASTROPHY FOR TWO WEEKS WHILE AWAITING PERMISSION TO BE ADM.

C.R.-AGE 65- ABD. PAIN AND WEIGHT LOSS. LIVES PETERSBURG. W.VA. ALSO. DENIED ADM. FOR MANAGEMENT. DX. OF PANCREAS CANCER DELAYED TWO MONTHS. MUCH EXCESS PAIN & SUFFERING FROM MEDICARE POLICY.

724 7666

THOMAS F. LEWIS, M.D., F.A.C.S., P.A.
RICHARD L. SNIDER, M.D., F.A.C.S., P.A.
PHILIP J. SCHROEDER, M.D., F.A.C.S.
MEMORIAL MEDICAL BUILDING, SUITE 201
MEMORIAL AVENUE
CUMBERLAND, MARYLAND 21502
POST OFFICE BOX 2455

BY APPOINTMENT

May 19, 1986

Wayne C. Spiggle, M.D.
Braddock Medical Group
912 Seton Drive
Cumberland, Maryland 21502

Dear Wayne:

In response to your preparation for the Committee on Aging hearing, I can supply you with the following: (1) Mr. L. R. who was a 72-year-old male forced to undergo a large left inguinal hernia repair as an in/out patient approximately one year ago. He returned to his home in a hotel in Frostburg, and the following the morning slipped on the ice while getting breakfast at a neighboring luncheonette. He presented to my office seven days later saying that after the slip he noticed a pain in his incision. Suffice it to say, he developed a large hematoma which gradually drained and subsided. Since that time he has a large recurrent inguinal hernia. I blame his slipping on the fact that he had to go to a luncheonette for his meals and should have been admitted to the hospital. (2) In aggregate, I have had approximately four patients that were greatly disturbed by the fact that they had to leave the hospital after having either hernia or hemorrhoid surgery. They felt that the pain that they endured by the forced activity by leaving the hospital was unnecessary and forced upon them by their Medicare providers.

I hope this will be of some assistance to you, Wayne. As the years go by, however, I do not remember the multiple incidences of small problems that have occurred because of the Medicare cutback.

If I can be of any further assistance to you please do not hesitate to call on me.

Sincerely,

Richard L. Snider, M.D., F.A.C.S.

RLS:sk

SUSAN F. SCHWARTZ, M.D.
Frostburg Plaza
Routes 36 and 40
Frostburg, Maryland 21532

Telephone 689-1050

June 4, 1986

Wayne Spiggle, M.D.
912 Seton Drive
Cumberland, MD 21502

Dear Wayne:

The following is a brief capsule of a case that had potential difficulty with Medicare regulations. J. A. is a 69 year old white male with severe Alzheimer's Disease and a one month history of generalized seizures secondary to an old cerebrovascular accident. He required multiple dental extractions and restorations for severe gingival disease accompanied by significant pain and it was felt, because of this patient's inability to understand or cooperate with the procedure, that it was wisest to perform this under general anesthesia. The dentist made a written request to PRO for pre-operative approval for at least a 24 hour post-operative stay in the hospital because of potential complications from dehydration because of probable inability to eat due to oral discomfort; possible seizures particularly in view of the fact that it was very difficult for the wife to administer the Dilantin to the patient at home and he was admitted with a Dilantin level that was less than therapeutic; the strong probability of post-operative oral bleeding; as well as the other usual post-operative complications such as pneumonia, etc., which would be difficult for the wife to assess in this severely demented patient at home.

PRO refused a pre-operative certification for post-op admission and the dentist and I, together, decided that we would admit the patient anyway. I was telephoned by the Quality Assurance Nurse the morning of surgery and advised that the Quality Assurance Office could not approve this admission and that if I insisted on admitting the patient Quality Assurance would then have to send a letter of refusal of Medicare payment to the wife. I advised that the hospital do this to protect itself and also advised Quality Assurance that I could not go along with discharging the patient home when I felt he was at high risk for post-operative complications, merely because PRO was refusing a pre-operative certification. Quality Assurance did advise me that if post-operative stay was uncomplicated, likely, retrospectively, the entire admission would be denied and I acknowledged that this probably was true, but in view of the fact that I could not predict the future I felt that it was unethical and medically unsound to send this patient home because of this type of administrative problem.

The patient underwent the dental surgery which was generally uneventful, although extra sutures were needed to stop bleeding during the surgery. Post-operatively, the patient was too sedated to even be transferred in and out of an automobile until at least 24 hours following surgery. He required intravenous hydration for a number of hours after surgery until he could take oral liquids. It was thought, at one point, that we would have to give intravenous Dilantin but eventually we were able to get his oral doses before going beyond too much time from the pre-operative dose. The patient, in fact, did not have seizures and did not become dehydrated (probably because of the intravenous hydration) and did not have excessive bleeding post-operatively and was seen by both myself and the dentist the night after admission and he was also seen the following morning.

At the present time I still do not know if retrospectively PRO will approve or deny this admission. I took extensive pains during the dictation of the discharge summary to go through the timing of events which included surgery at 9:00 AM, arrival in the recovery room at 12:30 PM, admission to the hospital at 2:30 PM, the initiation of oral liquid feedings at 6:00 PM, etc. I think it certainly would have been most unreasonable from a prospective viewpoint to try to guess what this patient's post-operative course was going to be; to hold him in the recovery room for a number of hours to decide very late in the day or the evening that eventually he did need to be admitted and I think that pre-operatively this certainly should have been approved. It would have avoided excessive amounts of paper work, telephone calls, trauma to the wife regarding a threat to deny payment for this hospital admission and anxiety of the hospital over whether this admission was going to be approved or denied. Certainly, if there are two opinions, particularly those of myself and the dentist, both of whom are competent professional people who do not abuse the Medicare system, I do think that PRO should prospectively approve this kind of admission and avoid the problems as discussed above and I also believe that we should not have to dictate into our discharge summary multiple, multiple details that ordinarily we would not bother with, simply for the purpose of stressing to PRO that, indeed, a stay in the hospital was medically justifiable. I was very clear with Quality Assurance that if PRO retrospectively denied this payment I would write letters to the appropriate politicians and would encourage the family to do so as well.

Of note is that this patient did develop a cough several days after going home and within one month was readmitted to the hospital with a bilateral pneumonia and I suspect that this had to do with the initial anesthetic event. I do believe that the pneumonia would probably have been more severe if the patient had been discharged immediately home and had not been able to receive the type of care that he did receive as an in-patient.

I hope this summary has been useful to you.

Sincerely,

Susan

Susan F. Schwartz, M.D.

SFS/bf

JUDY STONE, M.D.
Internal Medicine & Infectious Diseases
500 MEMORIAL AVENUE
MEMORIAL MEDICAL BLDG. SUITE 103
CUMBERLAND, MD. 21502

Telephone: 301-777-8088

May 21, 1986

Wayne C. Spiggle, M.D.
912 Seton Drive
Cumberland, Md. 21502

Re: COMMITTEE ON AGING HEARING

Dear Dr. Spiggle:

Although I am one of the younger and newer physicians in Cumberland, I too am concerned about the effect of the Medicare requirements on patient care and would like to offer any assistance I can for your preparation for the upcoming hearing. Enclosed are brief abstracts on several patients that I have seen recently who have been effected by these changes in Medicare.

G.V. is a 85 year old white male from Petersburg, WV. He was initially seen by me in consultation for a chronic draining sinus tract in his elbow which we found was due to tuberculosis. Subsequently, he developed back pain and difficulty ambulating and required vertebral biopsy to try to establish the diagnosis of Pott's disease. We were told that this procedure would have to be done on an outpatient basis despite his age and difficulty ambulating and the distance that he has to travel. It required a great deal of argument and effort on the part of myself and Dr. Ashker to pursuade Utilization Review that he required hospitalization for evaluation of possible neurological deficits and to insure adequate diagnosis and treatment.

A.R. was a 62 year old white male with metastatic lung carcinoma and admitted for acute respiratory failure. Utilization Review questioned his hospitalization by the 3rd or 4th day of admission and an argument ensued since he was essentially admitted for terminal care. The patient had a great deal of anxiety throughout his hospitalization over the threat of "being cut off". He felt that he was too weak and ill to go home and the hospice setting was not available at the time. Frankly, to justify his hospitalization and meet criteria, he was ultimately kept on uncomfortable aerosol treatments and parenteral treatments when he would have perhaps been more comfortable being given comfort measures alone. The patient, however, was desperate to stay in the hospital and he and I spent long sessions discussing his treatment and desire to stay in the hospital until his death, which subsequently did occur.

E.T. is a 72 year old white male who was admitted with a complaint of back pain. He was subsequently found to have both the vertebral compression fracture and an abdominal aortic aneurysm. He ultimately did not "meet criteria" because no active medical intervention was undertaken. However, the Utilization Review ignored the fact that the patient, who had not been previously ill, needed some time to consider the options and decide whether

he was going to have major surgery to repair the abdominal aortic aneurysm. Apparently they expected an instantaneous decision and when, he decided against the surgery, that last period of admission was denied because nothing was being done that met their criteria.

M.M. is an 81 year old white female who was admitted with back pain secondary to a vertebral compression fracture. Again, there was a great deal of anxiety over her admission because there was no treatment that was necessary other than analgesics, but she felt that she could not go home until she was better able to ambulate and resume caring for herself.

Finally, B.S. is a 77 year old white female with COPD as the most active medical complaint who was recently hospitalized by me. Although she complained of feeling weak and "not herself and not ready to go home", she ultimately was pressured into going home because again she did not meet criteria for continued stay in the hospital. She immediately bounced back with sepsis secondary to pyelonephritis within three days of her discharge and I feel that perhaps had we been able to observe her longer, we would have sooner identified why she was non specifically not feeling well.

These are just a few of the examples of patients I have recently seen. I think overall, I would like to emphasize that the criteria reflect a lack of compassion as in the case of A.R., who was troubled until his death, that he would be evicted from the hospital. It is unfortunate that, particularly these elderly patient's illnesses are complicated by the burden of these arbitary criteria for hospitalization.

The other point that I would emphasize is that the criteria ignore the fact that many of our patients are elderly and travel a great deal of distance as do our patients from Petersburg and Oakland and that having to undergo these procedures as an outpatient additionally places an undue burden on them.

I hope that you find this helpful; please let me know if I can be of further assistance. I look forward to seeing you at the Committee Hearing.

Sincerely,

Judy A. Stone, M.D.

JAS:cs

Wayne,

I found some more cases when checking my PM 3 records. Excuse the typing. Notice. No cases in 1981, 1982, and 1983 except one Hospice case. All early discharge deaths 1984 and on. All discharges within 1-3 days of death.

Paul

Medical Examiner cases 1981-1986 Recently discharged from Hospital and died

??? WP. 7/6/82 Terminal Ca of lung. Discharged from hospital. Recent. Died at home. Hospic

D.M.S. 4/21/84 Discharged from hospital 4/19/84. Atrial fibrillation, congestive heart failure, uncontrolled diabetes. 70 year old female. Died, hom SHH

JWJ 5/4/84. 60 year old male recently discharged, ca colon, aortic stenosis, congestive heart failure, chronic seizure disorder Died E.R.(M.H.)

MVR 2/13/84 87 year old female. Ca colon. Recently discharged from hospital. At home.

ARH 10/29/84. 81 year old female with Hx of heart disease recently discharged. Died in E.R.

AB 12/24/84 81 year old male. Recently discharged from hospital. Hx of pneumonia, heart disease, CVA, diabetes. Died at home.

At home FW 1/27/85 Recently discharged from SHH. Body released to Dr. Brezda. 71, female

At home WB 1/28/85 Recently discharged from MH. Body released to Dr. Fiscus. 92 male.

CWD 2/20/85 Recently discharged from SHH, chronic lung disease and pneumonia. Died at home.

JHG 5/9/85 Disharged from SHH 5/8/85, cardiac arrythemia. DOA. MH

WC 5/13/85 Discharged from hospital 5/7/85. Diabetes, heart disease, liver disease. Died at home.

GMB 5/27/85 Recently discharged from hospital, Dx heart disease, fractured hip. Died at home.

GCE 8/4/85 80 year old female discharged from hospital 8/2/85. Heart disease. Died at home 2 days later.

WIG 12/3085 81 year old male. Recently discharged from SHH, heart disease, congestive failure, gastric lymphoma. Died at home.

EE 1/5/86 Recently discharged from hospital Dx, renal failure, atrial irritability, anemia, sepsis. Died at home. 86 year old female.

VE 1/13/86 87 year old female recently discharged from West Virginia hospital Hx of aortic stenosis and fractured clavicle. Died at home.

BLB 4/17/84 47 year old female discharged from MH 2 days prior to death. Had seizure disorder, and gall bladder disease. Anemia. Fell at home due to weakness. DOA M.H. Autopsy revleaded purtured spleen. Medical Examiner case after autopsy done. Autopsy done by Dr. Snow. Investigation report completed by Dr. Mastrangelo.

Paul Snow, M.D.
Dpty Medical Examiner, Allegany County Maryland

Braddock Medical Group
PROFESSIONAL ASSOCIATION

912 SETON DRIVE
CUMBERLAND, MARYLAND 21502
TELEPHONE (301) 722-3111

INTERNAL MEDICINE

W. C. SPIGGLE, M.D.
VICTOR E. MAZZOCCO, M.D.
GEORGE M. BREZA, M.D., F.A.C.P.
BRUCE D. BEHOUNEK, M.D.
RICHARD G. SCHMITT, M.D.

FAMILY PRACTICE

PAUL T. LIVENGOOD, M.D.

Dr Brace

March 7, 1986

The Honorable Paul S. Sarbanes
United States Senator
1518 G.H. Gallon Federal Building
31 Hopkins Plaza
Baltimore, MD 21201

RE: Marguerite MacMillan

Dear Senator Sarbanes:

Mrs. MacMillan died last night. Despite her death I hope you will proceed to deal with the Medicare problem which compounded the anguish of her last days.

Her death was premature. She did have cancer but she had a chance for a remission sufficient to give her a few more months of good life. The physicians who cared for her are in agreement that her Medicare problem contributed to her premature death.

Twenty-five years of practicing medicine has taught me how important it is for a patient who is facing a serious illness to have a positive attitude and to have some control over the dynamics of living.

No one representing Medicare came to Mrs. MacMillan's bedside with assurances that she was to be taken care of in a responsible fashion by a system designed to afford her dignity and health care she rightfully deserved. The way Medicare is being conducted these days gives the elderly every reason to be worried that serious illness will bring them financial disaster. In Mrs. MacMillan's case, the uneasiness of the threat that she may not qualify for Medicare benefits contributed to her death. I do not think that a sick person's energies should be diverted to these anxieties when they are needed to cope with the realities of life and death. I resent this intrusion into my ability to truly care for my patients.

Again, I suggest that if you and your colleagues could bring about a change in the Medicare law so that if the needs of a patient are not met by Medicare criteria, those criteria can be set aside if reasonable and humane care is at

stake. This could be done by making changes in the law which would allow me to consult with a responsible member of the hospital Utilization Committee to obtain concurrence that my patient's needs are not being fulfilled by those criteria. That concurrence met, my patient's needs can then be met also if the criteria are subjugated to that consultation.

It is wrong for a patient to be told in the hospital admissions office or even at his bedside that his safety net is about to be pulled away from him because he no longer meets these artificially designed criteria. A patient's needs cannot be placed in a test tube. Who is the best observer and assessor of a patient's needs? I submit to you that it is the physician. If that physician must seek concurrence from a responsible member of the hospital Utilization Committee, it seems to me that the needs for the system be properly utilized is given satisfactory attention.

Thank you for considering this suggestion.

Yours truly,

Wayne C. Spiggle

W.C.Spiggle, M.D.

WCS/fd

ANALYSIS OF IMPACT OF GOVERNMENT REGULATION ON
CARE OF THE MEDICARE POPULATION

George Brega MD
6/1/86

Much of the changes that are occurring today in health care relate to controlling health care costs. My personal analysis suggests that third party interventions are a prime mover in creating many of the difficulties were are faced with today. As an example, physician profiles traditionally are determined for new physicians after they have been in practice for a year or after there has been a fee change. These profiles have been developed without questioning the charges, especially for a new physician in practice, who could start his fees at extremely high level, recognizing that it will be a year before he will obtain full reimbursement. Third parties also seem to be impressed with technology, especially new technology, and surgical procedures and have paid bills without assessment of what the actual costs were in relationship to the benefit of the procedure or the technology. Several studies have estimated at 30-35% o f daily hospital charged are related to meeting bureaucratic regulations. Some other examples might reflect the fact that a lab profile done in Cumberland Maryland costs $29.00 done by the same national laboratory nd $84.00 in Rockville, Md., The third parties reinbursing a similar percentage in both incidences.

Some of the solutions that are being proposed are efforts to shorten hospital stay, questioning whether procedures are done in or out of the hospital, use of DRG' s professional review organizations. My personal assessment is that the emphasis is more on cost containment rther than quality of care. The most recent AMA issure shows that Medicare has a way of "obtaining a float on interest". It is withholding or slowing down the payment of providers, whether they be hospitals or physicians. They are a pparently saving 2-3million dollars a day but the excess cost administratively is in the range of 7 million dollars a day. Additional observation is that much of the bureaucratic organizations reviewing quality of health care are self -serving , looking to protect their own bureaucratic niche more than benefitting the public. As an example, the patient of mine, Susan Howsare, is applying for MEdicaid eligibility. The local

agent requests that a copy of all her medical records, which was no insigificant expense to copy all of our records. When I questioned why he needed this, he did not give me an answer that made any degree of sense except to say if I felt otherwise he would just send the patient to Memorial Hospital for complete physical examination, chest xray, EKG, etc. so that he would have an up to date assessment . The patient has already been on medicaid so they will be footing the bill for his decision. The final commentary is that medicine is probably one of the most regulated areas in the United States today, and we have already had the experience that excesssive regulation leads to excess costs without benefits to the public. We ultimately will be faced with Easter Island Syndrome, where society is spending more of its energies on the system rather than goals and lead to the destruction of Easter Island

~~Society~~

Added by: Charles Parker 80+ y/o w/ CAD, CVA, dementia, lives alone
CVA - hosp denied while awaiting NH placement -
cannot get great distress pending placement

SAMUEL M. JACOBSON, M. D., F.A.C.P.
DIPLOMATE AMERICAN BOARD INTERNAL MEDICINE
Fifty Pershing Street
Cumberland, Maryland 21502

May 14, 1986

Wayne C. Spiggle, M. D.
912 Seton Drive
Cumberland, Md. 21502

Dear Wayne:

I have your undated communication in regard to the Hearing on Aging.

For a long time I have been saying to various Utilization representatives that I do not treat Insurance Plans, Medicare Schedules, nor Hospital Rules. I treat people.

No doubt all of the rules and regulations disregard the elderly. While I do not specify specific cases, there is no consideration for an old person who in many cases must take care of themselves. Many of them are ready to leave the hospital but not ready to take care of themselves. What we need is a "Tweener Hospital" where people who are ready to go home can go for several days or a week until they are able to care for themselves.

In addition, many elderly people, if they could stay in hospital for an extra day or so to get stronger, it would help them a great deal and also the various Hospital Insurance plans.

Good Luck and Success in this endeavor.

Sincerely yours,

Samuel M. Jacobson, M. D.

SMJ: mvd

VILLAGE
Frostburg
OF ALLEGANY COUNTY
One Kaylor Circle • Frostburg, Maryland 21532-2099 • (301) 689-2425

CONGRESSIONAL FIELD HEARING
ON
MEDICARE PAYMENTS AND QUALITY HEALTH CARE FOR RURAL OLDER AMERICANS

June 9, 1986, 10 a.m. to 1 p.m.

In the elderly population there is a delicate balance and interaction between physical and mental health:

1. Mental problems may lead to physical consequences; eg. stress and anxiety leading to gastrointestional complaints.
2. Physical factors may result in psychiatric symptoms; e.g. hearing loss leading to delusional thoughts.
3. Mental health problems often are associated with physical problems, e.g. cardiac problems associated with an occurrence of depression.
4. Physical health problems may be aggravated by a lack of adequate social support, e.g. diabetic living alone who can not care for an infected foot is in risk of losing the foot. Statistics suggest that 41% of older women and 15% of older men live alone. Approximately 7% of all elderly are confined to home.
5. Older people are more highly susceptible to medication side effects. Psychotropic medications may lead to physical side effects, while medications for physical illness may lead to psychiatric symptoms. A combination of medications for both problems may lead to drug interactions.

For these reasons it becomes extremely important for elderly individuals presenting psychiatric or physical symptoms to have a thorough and comprehensive assessment and followup evaluation of treament by a knowledgeable practitioner trained in geriatric medicine. Included in the evaluation, a functional assessment of how the individual may function at home within given limitations, is necessary for family members and/or involved caregiving agencies. In this way, expectations are appropriate to the patient; necessary changes in environment, treatment, or support systems can be made; and premature institutionalization can be avoided. This screening and assessment is particularly important for individuals having Alzheimer's disease and other dementias as well as for individuals experiencing dementia-like symptoms, which can be reversed through assessment and appropriate treatment.

Presently, this type of assessment is available at Johns Hopkins University and

Equal Housing Opportunity

at other research centers in the country, providing an invaluable service to those individuals close by. It is clearly unavailable to individual and families in rural areas. Much of the work done at these centers is funded through research grants, not by Medicare and other private insurances. However, through proper assessment, expensive but unnecessary treatment, like institutionalization, may be avoided. It is important that policy makers consider making Medicare payment available for comprehensive multidisciplinary evaluation to help older people and their families decide on appropriate and more cost-effective health care.

Leo J. Cyr, Administrator
Suanne Ostendorf, Social Services Director
FROSTBURG VILLAGE OF ALLEGANY COUNTY

UNIVERSITY OF MARYLAND AT BALTIMORE
ELDER — HEALTH
PARTNERSHIP IN CARE

School of Pharmacy • 20 North Pine Street • Baltimore, Maryland 21201 • (301) 528-7613

STATEMENT

I am president of the Maryland Pharmaceutical Association, Director of the Elder-Health Program, University of Maryland School of Pharmacy and a home health care pharmacist with ASCO Pharmacy of Silver Spring, Maryland. I am delighted to speak to you as a member of an interdisciplinary team of faculty from five departments of the University of Maryland who are working together in a geropharmacy project funded by the Andrus Foundation, the research arm of the A.A.R.P. ~~(See attached article, Rural pharmacists get special training to help elderly, Drug Topics, January 1986).~~

Why pharmacy? Research has shown that almost a third of all prescription medicines are being misused in a manner that poses a serious threat to the elder's health. It is estimated that 1.5 million persons are hospitalized yearly because of adverse drug reactions. Instead of helping to maintain elders in the community and helping to delay dependency, drugs may decrease the quality of the elder's life and precipitate placement in an institution. Yet when used correctly drugs are the most cost-effective modality of chronic care!

We believe the rural community pharmacist is well-positioned to monitor drug action among neighbors who are his customers. This is particularly important for the elderly individual with multiple diseases, multiple physicians, and multiple drugs. Changes due to aging, often accompanied by physical and mental impairment, require close monitoring to assure optimal therapeutic outcome and to minimize risk. Use of non-prescription medications, vitamins, food supplements and home remedies, may interfere with prescribed medications and need to be closely supervised by the pharmacist as well.

Currently, the Federal Government mandates that pharmacists monitor the drug regimens for patients in skilled care nursing homes. A multitude of studies report the effectiveness of pharmacist-monitoring by a reduction in the number of drugs taken, reduction in the number of hospitalizations and reduction in the number of drug administration errors made by nursing staff. The need of the chronically ill, community-based patient for careful monitoring may even be greater than for his institutionalized counterpart who has 24 hour medical supervision. Reimbursement for this service should be mandated for elderly recipients of home health care or other federally funded health care services.

Finally, we need to look at reimbursement to pharmacists for special packaging systems which will reduce drug-taking errors, simplify drug administration by family members or other non-professional caregivers, simplify monitoring of patient compliance and promote patient education. Pharmacists are increasingly offering such systems to elderly "high risk" patients. The Maryland Medical Assistant office is now considering reimbursement for pharmacists who use these types of compliance systems for Medicaid recipients.

Thank you.

Madeline Feinberg

Madeline Feinberg, Pharmacist

Peter P. Lamy, Ph.D. — Madeline Feinberg, *Pharmacist*
Research Program • Center for the Study of Pharmacy and Therapeutics for the Elderly
Service Programs • Elder-Ed Program • Visitation Program • Caregivers' Program
• The Parke-Davis Center for the Education of the Elderly

(Submitted by Sue Davis, Cumberland Area Health Education Center)

GARRETT COUNTY SUMMARY OF ELDERLY

- 4376 persons over 60
  867 below the poverty level

- high concentrations and number of elderly poor in Accident and Friendsville. Low percentage but high actual number of elderly poor in Grantsville, Mt. Lake Park, and West Oakland.

- Transportaion - 2,000 elderly lack transportation or access to services

- Health - cost of health care is the single major concern expressed by poor elderly

- Housing - high percentage of elderly are homeowners with need for home rehabilitation 300 - 400 estimated need

- Home maintenance - Energy cost are primary concern. 1,145 elderly households in need

- In-home services - 400 - 500 elderly persons over 64 are in need of in-home services

- Nutrition - estimated 1,000 seniors in need of congregate or home delivered meals

- Socialization - Need for Senior Centers in Communities with large senior populations

- Garrett County Social Security beneficiaries age 62 and over -
  1,626 Male
  2,117 Female

MEDICAL SERVICES

Hospitals

Garrett County

Garrett Memorial Hospital: 76 beds consisting of 61 in medical/surgical, 7 in obstetrics, 4 in pediatrics, and 4 in critical care.

Allegany County

Thomas B. Finan Center: 200 bed State mental institution consisting of 72 in geriatric care, 66 in adult services, and 23 in adolescent services.

Frostburg Community Hospital: 50 beds consisting of 47 in medical/surgical and 3 in critical care.

Memorial Hospital: 278 beds consisting of 216 in medical/surgical, 20 in obstetrics, 19 in pediatrics, and 15 in critical care.

Sacred Heart Hospital: 247 beds consisting of 174 in medical/surgical, 20 in pediatrics, 19 in psychiatric care, 12 in obstetrics, 10 in critical care, 8 in alcoholism, and 4 in hospice care.

Washington County

Brooklane Psychiatric Center: 40 beds utilized in providing psychiatric services.

Washington County Hospital: 379 beds consisting of 309 in medical/surgical, 37 in pediatrics, 25 in obstetrics, and 8 in critical care.

Western Maryland Center: 155 beds relating to chronic disease and rehabilitation services.

(Submitted by Andrew E. Mance, M.D.)

by Andrew E. Mance, MD

Welfare in the Good Old Days

In the early 1930s, the federal government established work programs to help people recover from the Great Depression. But when the economy turned around, the bureaucracy reversed its attitude, encouraging Americans not to work. Today, more people than ever before are totally dependent on federal assistance.

I practiced medicine for 20 months before World War II. Occasionally, a county commissioner would ask me to treat a patient at no charge. In 1940, I saw six to eight patients a month who had asked public authorities for help.

In 1946, the deputy health officer announced to Garrett County physicians that the state of Maryland had set up a system to take care of the indigent. The plan sounded reasonable: It gave the poor easier access to medical care and paid physicians $2 for an office visit and $3 for a house call. The latter fee was much less than the customary charge at the time, but doctors went along with it because they were glad to help the needy and, besides, there didn't seem to be that many poor people.

> ... there didn't seem to be that many poor people.

After the county medical welfare program began Jan. 1, 1947, I found that there were more poor people in the area than I had realized. But I had no problem making ends meet, charging 50 cents to $2.50 for office visits and $50 for home deliveries, including pre- and post-natal care. With only six physicians serving a population of 25,000 spread out over 762 square miles, I kept busy. My daily schedule included 40 to 50 patients, so I worked 16 to 20 hours a day. The extra money, of course, didn't hurt.

But I noticed a gradual change in some of my patients. For example, an old woman who had been coming to my office regularly for her liver shot told me, "I just can't wait in the office anymore. I have 'the card,' so won't you come to the house to give me my shot?" I had to turn down her request because I didn't have the time.

On another occasion, I received a late-evening phone call from an elderly gentleman. At 12:30 a.m., after completing my office work, I

Continued on page 36

drove 10 miles to his home. He was sitting up in bed, looking quite comfortable. He said he had a cold, and he was right. I left him some medicine and prescriptions and went home to bed. I had earned $3.

That same morning, about 7:30, I got a call from one of my regular patients, who had been sick since 5 a.m.

"Why didn't you call me then?" I asked her.

"Doctor, I wouldn't call you at that hour. I know you need your rest," she answered.

The woman lived only a mile from my office. She didn't have a welfare card, but she did have pneumonia. Subconsciously, I wondered why the man with the cold and the welfare card didn't show me the same consideration she had.

On another occasion, I treated a patient who usually had paid after each visit. But now she had a state medical card. I gave her some prescriptions, which she got filled before stopping at a tavern at the edge of town to drink beer.

Once I stopped at a pharmacy on the way home from work. The druggist, who knew everyone in the county, mentioned that a patient who had visited my office that morning had brought in the welfare prescriptions I gave him, then purchased two bottles of Hadacol for $7.50.

Envy and Greed

I thought it interesting that the man had no money for the druggist or the doctor, even though their combined bills were less than the cost of the patent medicine he bought off the shelf. Although the pharmacist and I eventually would be paid, the situation still bothered me.

About a month later, a well-groomed, well-nourished and well-dressed woman with a nice fur coat and a lovely fur hat visited my office. As I handed her the medicines I had prepared and instructions on how to take them, she asked, "Is this card any good?"

"Yes," I answered, "but if you had told me you had the card a little sooner I could have saved making up the medicines."

As I was writing out the state prescriptions, I decided to ask some questions. I found out the woman, who had five grown children, lived on a 35-acre farm outside of town. I asked her why she got her welfare card. "Our neighbors have one, and we feel we are entitled to have one as much as they," she answered.

But when I gave her the state prescriptions, she confessed that she would be ashamed to take them to her pharmacist to have them filled. It was not really need, but envy and greed that had driven her to get the card. Her illness was not treatable with ordinary medicine.

The symptoms of that disease I saw 38 years ago were selfishness, envy, greed, dishonesty and lethargy. Its unfortunate victims lacked pride, foresight, self-esteem and respect for others. The system that had spawned the disease provided an ideal environment for its rapid spread.

If an individual tried to work, his check was cut by the amount he earned. It was easier to give up and become a slave to the system.

In September 1947, when funding for the program ran out, I took that opportunity to stop permitting patients to pay me with the card. I had nothing to lose, because I would have cared for these patients whether they paid me or not.

Many of my older patients told me they didn't like the medical card in the first place. I did lose some patients — those who tried all the doctors in town because the visits were free. But rather than faltering, my practice prospered. When the state medical care plan was funded again in January 1948, I continued my policy not to honor the welfare card.

Setting an Example

For centuries, people have dreamed of freedom, the concept on which this country was built. There was no way I could tolerate the degradation of the person, the destruction of initiative, self-esteem, respect for others, and respect for my country that the welfare system encouraged. I wanted the privilege to practice medicine in freedom — not according to the principles of the bureaucracy.

Today, physicians should set an example by refusing to let politicians use them to garner votes. Each patient should be treated on an individual basis, without regard to cost or payment. Under no circumstances should physicians be intimidated by any law other than the law of good medicine.

Americans should remember that they have a great asset — the freedom to choose their own physicians. When they lose that right through bureaucratic control, it follows that they soon will lose their personal freedom. FP

Dr. Mauer practices in Oakland, Md.

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the hearing, a form was made available to audience members who wished to make comments and recommendations but were unable to testify because of time limitations. The following are excerpts from the replies received:

Please consider Medicare payment for a one time assessment in a Geriatric Assessment Unit. This is a special unit to determine the needs of an older person and is composed of a geriatrician, R.N. and social worker. Cost: $100.

Ann T. Boyd
Frostburg, MD.

We need people from our own areas, Allegany and Garret Counies, on this Peer Review Organization (PRO) appeal board and on their review board. Our areas are very different from the large cities. Our people also have many different problems. Let our doctors decide when and how long we have to be hospitalized. We should not be pushed out of hospitals because Medicare says we can only stay four days. This was done to me after a stroke.

Hilda Van Meter
Cumberland, MD

Some agency should be set up where the aged or senior citizen can turn to and have the necessary forms filled out for Medicare benefits. Is the National Committee to Preserve Social Security and Medicare a justified organization?

J. Francis Fatkin
Frostburg, MD

The criteria for admitting elderly people to the hospital need to be reviewed. Adjustments are needed to include the social aspects as well as the economic aspects. True, you must not bankrupt the fund; however a second look at this must be given. I have just retired after thirty years with the American Heart Association in Allegany and Garrett Counties, MD, and I have empathy with all disabled heart patients, stroke patients, and hypertensives. The problem is truly great. Please, give it your best scrutiny! Thank you Beverly Byron and Don Bonker. Fight for us!

Ora Mae Lewis R.N.
Cumberland, MD

There is no check on the quality of care! Medicare is impotent. It has no power!!! The providers do pretty much as they please!!! We need consumers - senior citizens - to do the checking. This system should be organized at once.
Medical societies are useless in this situation. They will not criticize a "brother". Don't depend upon the medical profession to insure quality of care. Let citizens have this responsibility. Give them power.

Mildred G. Breckohr
Westminster, MD

Is there a safe answer from the Peer Review Organization concerning the patient's release from the hospital? We need local personnel on the appeal and review boards. Please let our physicians decide how long our hospital stay should be, not Medicare.

Elizabeth V. Connelly
Cumberland, MD

The use and continued use of home oxygen should be determined by the doctor caring for the patient, not by a Medicare board. No one is going to use oxygen unless he needs it The price of oxygen is beyond the financial means of those who need it.

More notice should be given that services under Medicare will end so that other arrangements can be made.

The price of home health care should be based on income and other expenses and not just on income. Fifty dollars an hour for home health care is beyond the financial means of the elderly.

Patients are sent home before they are able to go home. As a result a few days later they are back in the hospital.

The medical appeal notice given to patients when they enter the hospital is buried in the back of a hospital booklet in very fine print, which the elderly can't read or understand.

The meals served at senior centers and those for homebound people are not designed for the needs of the elderly. They have too much salt, too many spices, and too much grease.

The above statements are the concerns of my parents, Mr. and Mrs. Donald Long. They are elderly, homebound, and unable to attend this hearing.

Dorothy J. Long
Williamsburg, PA

The duty of Congress is to provide for the common defense as well as to provide for the general welfare of the people. This administration has provided a blank check for the Defense Department. General welfare programs, which should include health, education, and many other programs, have been gutted with no care for the old, the sick, and the poor. Defense is fine when handled properly but not nearly as important as the general welfare of the people.

D. J. Corley

Medicare rarely covers the cost of nursing home care because it only pays for "skilled care." People usually either need to pay privately or seek Medicaid coverage. People on Medicare have the misunderstanding that nursing home care, regardless of the skill level, is covered by Medicare.

Michael Stevens
Cumberland, MD

Our rehabilitation agency provides speech pathology, physical therapy and audiology services in hospitals, homes, nursing homes, day care centers, and offices. We are constantly faced with problems regarding medicare coverage for our services. Coverage is not uniform and in many cases does not allow for variations in the degree of severity or the extenuating circumstances of each patient and/or family. We are attempting to provide quality and continuity of care. A number of patients can only receive care delineated through minimum coverage. This entails lots of paperwork and regulations. There is always the threat of a denial of payment even though we, as professionals, have deemed the treatment appropriate for the patient.

Carol K. Clulee, M.Ed. CCC-A/S
Cumberland, MD

I do think that hospitals send patients home too soon after an operation and/or serious illness. You also have to go to the dispensary as an out-patient for several tests instead of going into the hospital to have the tests done all at once. It is a lot of trouble for an older person to get to the hospital for so many tests, so many different times.

Mrs. Hazel Poland
Wiley Ford, WV

Diagnosis-related groups (DRG) mean early discharge of patients, "sicker and quicker." Many families, particularly the elderly, do not have the support structure and coping ability to care for the sick family member on a 24 hour basis. Earlier discharge of patients has changed home health care. Basically, home health care provides skilled care on an intermittent part-time basis, thus leaving the family member with the remaining care.

Many of the elderly aren't aware of their rights, especially regarding their ability to challenge early discharge from the hospital. Hospitals often have either no discharge planning or poor discharge planning. The DRG program needs looking at and needs to be more flexible.

Everyone should have the right to quality home care regardless of economic status. There are many proprietary agencies, hospital based home care agencies, and other so-called "not for profit home health agencies" that skim off the cream. They take only home health patients who have a third party source of payment. Once these third party benefits are exhausted, they literally "abandon" the patient.

The proprietary section of the National Association for Home Care came out with a written statement, "Statement of Charity Care by Proprietary Agencies." This statement alludes to the fact that the responsibility for the care of the indigent, the gray-area patient who doesn't qualify or no longer qualifies for Medicare or Medicaid, and who has no other third party benefits, is now the responsibility of the public agency (tax supported agency).

All agencies, including the proprietaries, should have impressed upon them the responsibility for taking a certain number of charity cases as part of their provision of service to the community.

Bernadine M. Malinoski RN, MPH, CAAA
Frederick, MD

Nutritional services outside of the hospital setting need to be provided Medicare coverage. Since a decreased length of hospital stay is common today, it becomes less and less possible to provide 1) nutrition counseling for therapeutic diets and 2) appropriate high calorie high protein diets to prevent or ameliorate malnutrition.

Malnutrition is common among elderly and can lead to longer and more severe illness.

Nutrition counseling has been well documented to show benefits for patients with diseases such as diabetes, coronary artery diseases, hypertension, and gastrointestinal problems.

Both booklets on Medicare available at today's hearing say nothing about coverage for this necessary service.

Betsy A. Taylor, RD, MS
Chief Clinical Dietitian
Memorial Hospital and
Medical Center
Cumberland, MD

We senior citizens are not receiving the care in hospitals that we should. We are being turned out of hospitals when we really are not able to come home and take care of ourselves, especially when we have had an operation. I think the doctor and patient should have some say as to how they feel about the patient going home to take care of himself. Keep patients in the hospital until they are able to be discharged, instead of sending them home prematurely.

Lester W. Powers
Ridgeley, WV

Continue to review doctors' fees and what might be over-charging by the hospitals for Medicare and other patients. This will keep insurance costs at a minimum.

Donald N. Cook
Midland, MD

I would like to have the Medicare deductable cut down.

Mary E. Leasure
Cumberland, MD

I am the social worker in charge of the Geriatric Evaluation Services in Garett County, Maryland. Each year, I see approximately 300 individuals, 55 years of age or older. Not only are Medicare regulations very hard for these seniors to understand, many are left with hospital bills due to inappropriate admissions that Medicare will not cover. I assist these individuals in applying for other funding sources. Seventy-five percent of these individuals need assistance with personal care in order to remain in the home. They must pay out of their own pockets. I feel Medicare should help keep people out of nursing homes and hospitals. Personal care assistance would help support individuals in their own home.

Donna M. McClintock
Oakland, MD